Attachment 3

Services:
General Provisions

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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1. Inpatient hospital services other than those provided in an institution for mental diseases.

_X__ Provided: ____ No limitations __X__ With limitations*

2.a. Outpatient hospital services.

_X__ Provided: ____ No limitations __X__ With limitations*

b. Rural health clinic services and other ambulatory services furnished.

_X__ Provided: __X_No limitations ___ With limitations*

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

__X_ Provided: _X__No limitations ___ With limitations*

3. Other laboratory and x-ray services.

_X__ Provided: ___ No limitations __X_With limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

__X__ Provided: ____ No limitations __X__With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

c. Family planning services and supplies for individuals of child-bearing age.

__X__ Provided: __X__ No limitations ____ With limitations*

*Description provided on attachment.

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5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

__X__ Provided: ____ No limitations __X__With limitations*

5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

__X__ Provided: ____No limitations __X__With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

__X__ Provided: ____ No limitations __X__With limitations*

Not Provided: ____

b. Optometrists' services.

__X__ Provided: ____No limitations __X__With limitations*

Not Provided: ____

c. Chiropractor's services.

____ Provided: ____No limitations ____With limitations*

Not Provided: __X__

d. Other practitioners' services. Identified on attached sheet with description of limitations, if any.

__X__ Provided: ____No limitations __X__With limitations*

Not Provided: ____

*Description provided on attachment.

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7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

__X__ Provided: ____No limitations __X__With limitations*

b. Home health aide services provided by a home health agency.

__X__ Provided: ____No limitations __X__With limitations*

c. Medical supplies, equipment, and appliance suitable for use in the home.

__X__ Provided: ____ No limitations __X__ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

__X__ Provided: ____ No limitations __X__ With limitations*

e. Other Medical services, supplies, equipment and appliances.

__X__ Provided: ____ No Limitations __X__ With limitations*

8. Private duty nursing services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

9. Clinic services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

*Description provided on attachment.

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10. Dental services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

11. Physical therapy and related services.

a. Physical therapy.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

b. Occupational therapy.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

__X__ Provided: ____ No Limitations __X__ With limitations*

Not Provided: ____

12. Prescription drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

b. Dentures.

__X__ Provided: ____ No limitations __X__ With limitations*

*Description provided on attachment.

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12. Prescription drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist. (continued)

c. Prosthetic devices.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

d. Eyeglasses.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: _X___

b. Screening services.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

c. Preventive services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

d. Rehabilitative services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

*Description provided on attachment.

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14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

b. Nursing facility services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

c. Intermediate care facility services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

15.a. Intermediate care facility services for individuals with developmental disabilities who are determined in accordance with section 1902(a)(31) of the Act, to be in need of such care.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

b. Including such services in a public institution (or district part thereof) for the mentally retarded or persons with related conditions.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

16. Inpatient psychiatric facility services for individuals under 21 years of age.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

*Description provided on attachment.

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17. Nurse -midwife services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

18. Hospice care (in accordance with section 1903(o) of the Act.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

19. Case management services and Tuberculosis related services.

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

__X__ Provided: ____ With limitations*

Not Provided: ____

b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.

____ Provided: ____ With limitations*

Not Provided: _X__

*Description provided on attachment.

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20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

__X__ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

__X__ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

____ Provided ____ No limitations ____ With limitations*

Not Provided: __X__

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act.

__X__ Provided: ____ No limitations __X__ With limitations

Not Provided: ____

23. Certified pediatric or family nurse practitioners' services.

__X__ Provided: __X__ No limitations ____ With limitations*

*Description provided on attachment.

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24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

__X__ Provided: _____No limitations __X__ With limitations*

Not Provided: ____

b. Services provided in religious non-medical health care facilities.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

c. Reserved.

_____Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

d. Nursing facility services for residents under 21 years of age.

__X__ Provided: ____ No limitations __X__With limitations*

Not Provided: ____

e. Emergency hospital services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

*Description provided on attachment.

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25. Home and Community Care for Functionally Disabled elderly individuals, as defined, described and limited in Supplement 2 to attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A..

_____ Provided: __X__ Not Provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are:

A. Authorized for the individual by a physician in accordance with a plan of treatment.
B. Provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and
C. Furnished in a home.

__X__ Provided

__X__ State-Approved (Not Physician's) Service Plan Allowed
__X__ Services Outside the Home also Allowed.
__X__ Limitations Described in Attachment 3.1-A, Page 10-1

27. An alien who is a non-qualified alien or a qualified alien subject to the five-year ban and is otherwise eligible for Medicaid is eligible only for care and services necessary to treat an emergency medical condition as defined in section 1903(v) of the Act.

28. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

_X_ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

___ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

*Description provided on attachment.

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Description of Service Limitations

1. Inpatient hospital services

a. Prior authorization is required for psychiatric inpatient care.

b. Chronic pain management is limited to inpatient services provided by a Department of Social and Health Services (department)-approved pain center in a hospital.

c. Long-term acute care services are provided in department-approved hospitals and require prior authorization. This is not sub-acute care; rather this is intensive acute inpatient care provided to patients who would otherwise remain in intensive care or a similar level of care outside of a hospital's intensive care unit.

2. a. Outpatient hospital services

(1) Hospital-owned institutional facilities that are hospital-based may provide outpatient hospital services to eligible clients when authorized by the department to do so.

(2) Freestanding hospital-owned institutional facilities that are nonhospital-based may provide outpatient services to eligible clients when authorized by the department to do so.

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3. Other laboratory and x-ray services

a. Laboratory services

Pathology services are considered to be the same as laboratory services. The department covers all these services that are inpatient hospital. Limitations shown below are for outpatient.

Drug screens only when medically necessary and when:

- Ordered by a physician as part of a medical evaluation; or
- As drug and alcohol screens required to assess suitability for medical tests or treatment. For opiate substitution and pregnant women clients in the department's contracted treatment programs, drug screens for monitoring alcohol/drug use are reimbursed through a contract issued by the department.

One each of the following, per client per day:

- Blood draw fee; and
- Catheterization for collection of urine specimen.

b. Radiology services

The department covers all these services that are inpatient hospital. Limitations shown below are for outpatient.

The following services require prior approval through the Expedited Prior Authorization (EPA) process:

- Outpatient magnetic resonance imaging (MRI);
- Positron Emission Tomography (PET) scans;
- More than one annual screening mammogram for clients forty (40) years of age and older (based on the National Cancer Institute (NCI) recommendations regarding screening mammograms); and
- General anesthesia for radiological procedures. Allowed only when the medically necessary procedures cannot be performed unless the client is anesthetized.

Portable x-ray services furnished in the client's home or a nursing facility are limited to films that do not involve the use of contrast media.

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4. a. Nursing facility services.

Prior approval of admission.

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4. b. Early and periodic screening, diagnosis, and treatment

Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a program providing EPSDT to persons under 21 years of age who are eligible for Medicaid or the Children's Health Program. In conformance with 1905(r) of the Act, all medically necessary diagnosis and treatment services are provided regardless of whether the service is included in the plan. Limitations do not apply other than based on medical necessity.

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5. a. Physicians' services

Exceptions for noncovered services and service limitations are allowed when medically necessary and prior authorized by the department.

(1) Critical care.
- A maximum of three hours of critical care per client per day.
- More than one physician may be reimbursed if the services provided involve multiple organ systems (unrelated diagnosis).
- In the emergency room, only one physician is reimbursed.

(2) Newborn care and neonatal intensive care unit (NICU) services.
- One routine NICU visit per client per day.
- Prolonged care and newborn resuscitation when the physician is present at the delivery (in addition to the one routine visit).

(3) Osteopathic manipulative therapy.
Up to ten osteopathic manipulations per client, per calendar year.

(4) Physical exams:
Routine physical exams are covered in specific instances, including but not limited to:
- EPSDT screening
- Nursing facility placement exams
- Disability determinations for Title XVI-related individuals
- Yearly exams for developmental disability determination (DDD) clients

(5) Physician care plan oversight.
Provided once per client, per month. A plan of care must be established by the home health agency, hospice, or nursing facility, and the physician must provide 30 minutes or more of oversight each calendar month to the client.

(6) Physician standby services.
Must be:
- Requested by another physician; and
- Involve prolonged physician attendance without direct (face-to-face) patient contact.

The service must exceed 30 minutes.

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5. a. Physicians' services (continued)

(7) Physician visits.

Limited to:

- Two physician visits per month for a client residing in a nursing facility or an intermediate care facility.
- One inpatient hospital visit per client, per day, for the same or related diagnosis.
- One office or other outpatient visit per non-institutionalized client, per day, for an individual physician, except for return visits to an emergency room.

Professional inpatient services during the follow-up period are paid only if they are performed on an emergency basis and are unrelated to the original surgery.

(8) Psychiatric services.

- Outpatient psychotherapy and electroconvulsive therapy, in any combination - one hour per day, per client, up to a total of twelve hours per calendar year. Includes family or group psychotherapy.

- Psychiatric diagnostic interview examinations - one in a calendar year unless a new mental health diagnosis occurs.

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5. b. Medical and surgical services furnished by a dentist

Short stay procedures also take place in ambulatory surgery settings.

(1) Non-emergent oral surgeries performed in an inpatient hospital setting are not covered. The exceptions to this are DDD clients and children 18 years of age and under, whose surgery cannot be performed in an office setting (e.g., orthognathic cleft palate bone grafting). Prior written authorization is required. Documentation must be maintained in the client's record.

(2) Orthodontic treatment is limited to medically necessary treatment, as follows, and only for children with, craniofacial anomalies or cleft lip or palate or severe handicapping malocclusion:

(a) Clients in the EPSDT program through age twenty (20);

(b) Clients in the children's health program through age eighteen (18);

(c) Clients in the CN program through age twenty (20).

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law

a. Podiatrists' services

(1) Foot care is covered only for specific medical conditions that must be treated by an M.D., D.O., or podiatrist.

(2) The treatment of flat feet, or non-medically necessary treatment of fungal disease is not covered.

b. Optometrists' services

(1) Frames, lenses, and contact lenses must be ordered from the department's contractor.

(2) The department covers medically necessary eye examinations, refractions, eyeglasses (frames and glasses), and fitting fees as follows:
- Every 24 months for asymptomatic adults 21 years or older; and
- Every 12 months for asymptomatic children 20 years or younger, and clients identified by MAA as developmentally disabled.

(3) The department covers medically necessary contact lenses, as defined in rule. Normal replacement for contact lenses is every 12 months.

(4) Exceptions to numbers (2) and (3) above will be considered for all individuals based on medical necessity.

6. d. Other practitioners' services

All other practitioners covered by the department include, but are not limited to, the following licensed practitioners: psychologists, respiratory therapists, certified pediatric/family nurse practitioners, advanced registered nurse practitioners, dental hygienists, denturists, chiropractors (for EPSDT only), dietitians, nutritionists, occupational therapists, pharmacists, physical therapists, podiatrists, radiological technicians, speech/language pathologists, audiologists, licensed non-nurse midwives, birthing centers, and registered nurses first assistants. These practitioners are limited to services within their scope of practice.

Counselors, social workers, and other practitioners are covered as specified in other sections of the State Plan and as approved by the department.

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6. d. Other practitioners' services (cont.)

(1) MAA does not cover services provided by:
- Acupuncturists
- Christian Science practitioners or theological healers
- Herbalists
- Homeopathists
- Naturopaths
- Masseuses
- Masseurs
- Sanipractors

(2) Licensed non-nurse midwives.
- To participate in home births and in birthing centers, midwives must be a MAA-approved provider.

(3) Psychologists.
- One psychological evaluation per client's lifetime is covered.
- Neuropsychological testing requires prior authorization.

(4) Registered nurse first assistants.
- Registered Nurse First Assistants (RNFA) must provide services under the direction of a performing surgeon.

(5) Dietitians.
Medical Nutrition Therapy is a face-to-face interaction between a licensed/certified dietitian and the client and/or client's guardian for the purpose of evaluating and making recommendations regarding the client's nutritional status.

The service must be medically necessary and the client must be 20 years of age or younger with an EPSDT referral.

(6) Freestanding Birthing centers.

Definition: A freestanding birthing center is a specialized facility licensed as a childbirth center by the State's Department of Health (DOH).

- The DOH licensed birthing centers that have a core provider agreement with the department are authorized to provide necessary facility services.
- Eligible clients must meet medical criteria.

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7. Home health care services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

(1) Applies to home health agency and to services provided by a registered nurse when no home health agency exists in the area.

(2) Approval required when period of service exceeds limits established by the department.

(3) Nursing care services are limited to:

(a) Services that are medically necessary;

(b) Services that can be safely provided in the home setting;

(c) Two visits per day (except for the services listed below);

.

(d) Three high risk obstetrical visits per pregnancy; and

(e) Infant home phototherapy that was not initiated in the hospital setting.

(4) Exceptions are made on a case-by-case basis.

b. Home health care services provided by a home health agency

Home health aide services must be:

(1) Intermittent or part time;

(2) Ordered by a physician on a plan of care established by the nurse or therapist;

(3) Provided by a Medicare-certified home health agency;

(4) Limited to one medically necessary visit per day; and

(5) Supervised by the nurse or therapist biweekly in the client's home.

(5) Exceptions are made on a case-by-case basis.

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7. Home health care services (cont.)

c. Medical supplies, equipment and appliances suitable for use in the home

Medical supplies, equipment and appliances must be:

(1) Medically necessary;

(2) Ordered by the treating physician; and

(3) In the plan of care.

All of the following apply to durable medical equipment (DME) and related supplies, prosthetics, orthotics, medical supplies and related services suitable for use in the home:

(4) Purchase of equipment and appliances and rental of durable medical equipment require prior approval.

(5) Must be billed separately under a DME provider number.

(6) Are subject to the requirements in Washington Administrative Code.

(7) Specific reusable and disposable medical supplies, prosthetics, orthotics, and non-durable equipment that have set limitations, require prior approval (PA) to exceed those limitations.

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility

Therapies are limited to:

(1) Clients who are not able to access their care in the community; and

(2) To medically necessary care.

When physical therapy and occupational therapy are both medically necessary during the same certification period in order to meet the client's physical or occupational therapy needs, the physician must document on the plan of care that the services are distinctly different and not duplicated.

Exceptions are made on a case-by-case basis.

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7. Home health care services (cont.)

e. Other Medical services, supplies, equipment and appliances

(1) The Oxygen and Respiratory Therapy Services Program provides oxygen and/or respiratory therapy equipment, services, and supplies to eligible clients who reside at home or reside in nursing homes when medically necessary.

(2) Home infusion-parenteral nutrition equipment and supplies are provided when medically necessary.

- One germicide and/or one antiseptic allowed on the same day. Justification for exceeding this limit must be documented in the client's file.

(3) The Medical Nutrition Program provides medically necessary nutrition and related equipment and supplies, when the client is unable to meet daily nutritional requirements using traditional foods alone, due to injury or illness.

Limitations described below do not apply to the Medical Nutrition Program for EPSDT purposes. Exceptions to these limitations are allowed based on documented medical necessity.

- A licensed and certified dietitian must evaluate all clients 20 years of age and younger within 30 days of initiation of medical nutrition, and periodically (at the discretion of the licensed/certified dietitian) while the client is receiving medical nutrition.
- Initial assessments limited to 2 hours (or 8 units) per year.
- Reassessments limited to no more than 1 hour (or 4 units) per day.
- Group therapy limited to 1 hour (or 4 units) per day.

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8. Private duty nursing services

The purpose of the Private Duty Nursing (PDN) Program is to reduce the cost of healthcare services through equally effective, more conservative, and/or less costly treatment in a client's home. The department's Medical Assistance Administration has oversight for the program for clients 17 years of age or younger. Eligible clients must meet all of the following: be 17 years of age or younger; need continuous skilled nursing care that can be provided safely outside an institution; and have prior authorization from the department. PDN Program services for thoseage 18 and older are administered by the department's Aging and Disability Services Administration, and are comparable to services for those under age 18.

The department contracts with State Licensed home health agencies to provide PDN services. Within the home health agency, private duty nursing services must be performed by a licensed and appropriately trained registered nurse and/or a licensed practical nurse. For persons 18 years and older with an approved exception to policy, a private (non-home health agency) RN or LPN under the direction of the physician can provide PDN services only when the geographic location precludes a contracted home health agency from providing services, or when no contracted home health agency is willing to provide PDN services.

PDN services meet complex medical needs for persons who require at least four continuous hours of skilled nursing care on a day-to-day basis. Services provide alternatives to institutionalization in a hospital or nursing facility and are not intended to supplant or replace other means of providing the services.

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9. Clinic services

a. Freestanding kidney centers

(1) Description of facility: A center devoted specially to treating End Stage Renal Disease (ESRD)

(2) Description of service: Peritoneal dialysis or hemodialysis for ESRD.

(3) Program coverage: Covered as an outpatient service when provided by a freestanding renal dialysis center or a freestanding community hemodialysis unit. includes physician services, medical supplies, equipment, drugs, and laboratory tests.

(4) Prior authorization: Required for the facility but not the physician. Initial authorization may be granted for up to three months. Reauthorization may be granted for up to twelve months.

(5) Reimbursement: This service is reimbursed according to attachment 4.19-B.

b. Freestanding ambulatory surgery centers

Allowed procedures are covered when they:

- Are medically necessary; and
- Are not for cosmetic treatment surgery.

Some procedures are covered only when they:

- Meet certain limitation requirements; and
- Have been prior authorized by the department.

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10. Dental services and dentures

a. Limited to selected medically necessary services for the identification and treatment of dental problems or the prevention of dental diseases. Some of these services may require prior authorization.

b. Crowns are covered only for children through age twenty (20) and require prior authorization.

c. Orthodontic treatment is limited to medically necessary treatment, as follows, and only for children with craniofacial anomalies or cleft lip or palate or severe handicapping malocclusion. Limits may be exceeded based on medical necessity.

(1) Clients in the EPSDT program through age twenty (20);

(2) Clients in the CN program through age twenty (20)

d. Clients of the Developmental Disability Division may receive additional services

e. Dentures

For limitations indicated in (1) below, limits may be exceeded based on medical necessity.

(1) For clients through age twenty (20), allowed per client:

- Complete, immediate, and overdenture dentures - one maxillary and one mandibular denture in a ten year period.
- Partial dentures - once every five years, subject to limitations.
- Replacement full or partial dentures - requires prior authorization when requested within one year of the seat date of the previous dentures.
- Rebase - once every five years and the dentures must be at least three years old
- Relines and adjustments - included in the reimbursement if done within six months of the seat date. After six months, allowed once every five years.

(2) For clients age twenty-one (21) and over, allowed per client:

- Immediate dentures - one maxillary and one mandibular denture in a lifetime, and requires prior authorization.
- Complete dentures - one maxillary and one mandibular denture in a ten-year period and requires prior authorization.
- Resin and cast metal framework partial dentures - once in a ten-year period and requires prior authorization.
- Replacement resin partial dentures – not allowed within the ten-year period.

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10. Dental services and dentures (continued)

- Replacement cast metal framework partial dentures - once in a ten-year period.
- Complete and partial denture relines - once in a five-year period.

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11. Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders

a. Duplicate services for occupational, physical, and speech therapy are not allowed for the same client when providers are performing the same or similar procedure(s).

b. Prior authorization required to exceed set limits for clients twenty-one (21) years of age and older as follows:

(1) Prior Authorization is required for physical therapy (PT) when the client is

- 21 years of age and older and requires services beyond one PT evaluation and 48 units PT per year, per client per diagnosis, or
- 21 years of age and older and has a qualifying diagnosis or has completed an approved inpatient rehab stay, and requires services beyond one PT evaluation and 144 units of PT per year, per client, per diagnosis.

(2) Prior Authorization is required for occupational therapy (OT) when the client is:

- 21 years of age and older and requires services beyond one OT evaluation and 12 OT visits per year, per client; or
- 21 years of age and older and has a qualifying diagnosis or has completed an approved inpatient rehab stay and requires services beyond one OT evaluation and 36 OT visits per year, per client.

(3) Prior Authorization is required for speech therapy (ST) when the client is:

- 21 years of age and older and requires services beyond one speech evaluation and 12 speech visits per year per client; or
- 21 years of age and older and has a qualifying diagnosis and requires services beyond one Speech evaluation and 36 speech visits per year per client.

c. Services for individuals with speech, hearing, and language disorders must be provided by or under the supervision of a speech pathologist or audiologist.

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12. a. Prescribed drugs

Drug Coverage

(1) Covered outpatient drugs as defined in Section 1927 (k)(2) of the Act are those which are prescribed for a medically accepted indication and produced by any manufacturer, which has entered into and complies with an agreement under Section 1927(a) of the Act.

(2) Prescriptions written as a result of an EPSDT visit will be approved as ordered by the prescriber when that information is communicated to the therapeutic consultative services (TCS) clinical pharmacists.

(3) Generic drugs, insulin and diabetic supplies, contraceptives, antipsychotics, anticonvulsants, antidepressants, chemotherapy, antiretrovirals, immunosuppresants and hypoglycemic rescue agents will be exempt from triggering a TCS review. During a TCS review, all covered outpatient drugs, as defined in Section 1927 (k) (2) of the Act will be authorized for the Medicaid client, if the prescriber deems them to be medically necessary.

(4) Under Washington Administrative Code, pharmacies are advised provide an emergency supply of medically necessary drugs when TCS reviews are pending.

(5) Drugs excluded from coverage as provided by Section 1927(d) (2) of the Act, include: DESI drugs, experimental drugs; weight loss drugs (unless prescribed for an indication other than obesity), drugs for cosmetic purposes, drugs for fertility and drugs for smoking cessation (except that Zyban is covered for pregnant or post-partum women according to Washington Administrative Code).

Prior Authorization

(6) Prescription drugs may be subject to prior authorization by the agency to ensure that drugs are prescribed and dispensed appropriately.

(7) MAA determines which prescription drugs may require prior authorization by reviewing the drug(s) for the following:

- Safety
- Potential for abuse or misuse
- Narrow therapeutic index
- High cost when less expensive alternatives are available

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12. a. Prescribed drugs (continued)

(8) Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization and provides for the dispensing of at least a 72-hours supply of medications in emergency situations.

Therapeutic Consultation Service (TCS)

(9) In the Therapeutic Consultation Service (TCS), all Medicaid recipients will have their entire drug profile reviewed by clinical pharmacists after the fifth request for a brand-name drug is processed in a calendar month or anytime a request for a non-preferred drug is processed. A non-preferred drug is a drug in a drug class that has essentially the same clinical safety and efficacy as the drug of choice, but is not the preferred drug. TCS is not a limit, but rather a service to provide a clinical pharmacy review of the client's entire drug therapy. This review is conducted to assure that Medicaid clients are receiving appropriate drug therapy, without therapeutic duplication or without potentially serious drug-drug interactions or drug-disease conflicts. Prescribers direct clients' drug therapy and have the final say. Reports will be available that indicate the numbers of prescriptions that were dispensed as originally ordered by the prescriber.

Supplemental Rebate Agreement

(10) The state is in compliance with Section 1927 of the Act. The state will cover drugs of manufacturers participating in the Medicaid Drug Rebate Program. Based on the requirements for Section 1927 of the Act, the state has the following policies for drug rebate agreements:

- Manufacturers are allowed to audit utilization rates.
- The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with Section 1927 (b)(3)(D).
- A rebate agreement between the state and a drug manufacturer for drugs provided to the Washington Medicaid population, submitted to CMS on January 14, 2002, entitled "State of Washington Supplemental Rebate Contract," has been authorized by CMS.
- A rebate agreement between the state and a drug manufacturer for drugs provided to the Washington Medicaid population, submitted to CMS on January 16, 2004, entitled "State of Washington Supplemental Rebate Contract," has been authorized by CMS.
- The state reports rebates from separate agreements to the Secretary for Health and Human Services. The state will remit the federal portion of any cash state supplemental rebates collected on the same percentage basis applied under the national rebate agreement.
- All drugs covered by the program, irrespective of a prior authorization agreement, will comply with provisions of the national drug rebate agreement.

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12. a. Prescribed drugs (continued)

Preferred Drug List

- Pursuant to 42 U.S.C. section 1396r-8, the State is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization, and provides for the dispensing of at least a 72-hour supply of medications in emergency situations, in accordance with provisions of section 1927(d)(5) of the Social Security Act. The prior authorization process is described in chapter 388-530 WAC.
- Prior authorization will be established for certain drug classes or particular drugs in accordance with Federal law. All drugs covered by the program, irrespective of a prior authorization requirement, will comply with the provisions of the national drug rebate agreement.
- A preferred drug list does not prevent Medicaid beneficiaries from obtaining access to medically necessary drugs of manufacturers that participate in the national drug rebate program.
- The State will utilize the Drug Utilization Review board to assure, that in addition to pricing consideration, preferred drugs are clinically appropriate.

Mail Order Delivery Service for Prescription Drugs

(11) The state contracts for a mail-order delivery service for prescription drugs using a competitive bid process. This service is available to all fee-for-service Medicaid clients statewide. Clients have the option of having prescriptions filled at either a local retail outlet of their choice or by the mail-order contractor.

All policies and procedures that apply to retail pharmacies also apply to the mail-order contractor, except for the following:

(a) The mail-order contractor is reimbursed at a mutually agreed upon level that is less than reimbursement provided to local retail pharmacies; and

(b) If authorized by the prescriber, the mail-order contractor may dispense the following drugs in up to a ninety-day supply:

(i) Preferred drugs identified by the state;

(ii) Generic drugs; and

(iii) Drugs that do not require prior authorization or expedited prior authorization.

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12. b. Dentures

These services have been moved under “Dental Services” based on CMS recommendation.

12. c. Prosthetic devices

(1) Prior approval required

(2) Hearing aids provided on the basis of minimal decibel loss

12. d. Eyeglasses (Included under “Optometrists’ Services”, section 6.b.)

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13. c. Preventive services

Disease State Management

The State of Washington will provide a statewide Disease Management Program to Medicaid clients eligible for Title XIX Medicaid coverage under the Categorically Needy Program (CNP), who receive services through the Medical Assistance Administration's (MAA's) fee-for-service system, and who have one or more of the following diseases:

- Asthma
- Congestive Heart Failure;
- Diabetes;
- End Stage Renal Disease (ESRD)or Chronic Kidney Disease (CKD);
- Chronic Obstructive Pulmonary Disease (COPD).

The State's Disease Management Program is designed to assist clients with chronic illness to achieve the following goals:

(1) Increase the client's (and/or their caregiver's) understanding of their disease so they are:

- More effective partners in the care of their disease;
- Better able to understand the appropriate use of resources needed to care for their disease(s);
- Able to identify when they are getting in trouble earlier and seek appropriate attention before they reach crisis levels; and
- More compliant with medical recommendations.

(2) Improve clients' quality of life by assisting them in "self-management" of their disease and in accessing regular preventive health care;

(3) Provide coordination among multiple case managers and health care providers;

(4) Improve adherence to national, evidence-based guidelines to improve clients' health status; and

(5) Reduce unnecessary emergency department visits and hospitalizations.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

13. c. Preventive services/Disease State Management (cont.)

Components of Disease State Management

Contracted disease management vendors will provide the following services to clients eligible for the program:

- Outreach that is sufficient to draw hard-to-serve clients into the program, including home visits or other face-to-face contact if the client does not have a telephone, or is unable to use the telephone.

- Twenty-four hour-a-day, seven days-a-week (24/7) toll free nurse telephone consultation and screening service staffed by licensed registered nurses. The toll free nurse service will provide advice and consultation to all clients in the enrollment group of 173,000 on a 24/7 basis. In addition, during each incoming call, the triage nurse will ask a series of questions designed to determine if the client has one of the conditions being served by the disease management program. If the caller has one of the conditions covered by this program, he or she will be transferred to either the McKesson Care Enhance program or the Renaissance ESRD program for further assessment and risk stratification.

- Once the client has been referred for further assessment, the appropriate contractor will provide more intensive screening to determine the client's risk level. The Contractor will then develop and implement an individual plan of care that addresses the client's multiple health, behavioral and social needs, and that ensures continuity, quality and effectiveness of care.

- Assistance to clients in accessing appropriate medical care, including assisting the client in finding a primary care provider (PCP) if the client does not already have a PCP.

- Assistance to clients in accessing necessary primary/preventive care and obtaining referrals for specialty services through appropriate channels, rather than obtaining care through the emergency department.

- Facilitation of appropriate collaboration between the client's family and/or caregivers, health care providers and community case managers in the development and implementation of the client's plan of care.

- Linkage between health care providers and allied health and social service agencies to facilitate access to services necessary for the implementation of the client's plan of care, including a system that allows providers to request specific care coordination services.

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13. c. Preventive services/Disease State Management (cont.)

Choice of Providers

The state assures that there will be no restrictions on a client's free choice of providers in violation of Section 1902(a)(23) of the Act. Eligible clients have free choice to receive or not receive disease case management services through contracted Prepaid Health Plans (PHPs) and may change nurse case managers within the PHP at any time. Eligible clients also have free choice of the providers of other medical care under the program.

Criteria for Disease Management Providers

(a) All Disease Management case managers shall be registered nurses who meet the requirements of the contracted disease management vendors.

All case management nurses shall be licensed in the State of Washington, Registered Respiratory Therapists licensed in the State of Washington may provide additional services.

(b) The State will contract with disease management companies who meet the program requirements.

(c) Entities who wish to contract with the Medical Assistance Administration to provide disease management services must meet the following conditions:

- Have an appropriate method for using MAA healthcare data to identify targeted disease populations;
- Have an evidence-based healthcare practice guideline for each targeted disease;
- Have collaborative healthcare practice models in place to include MAA's contracted physicians and support-service providers;
- Have patient self-care management education materials and methods appropriate to each targeted disease population;
- Have process and outcomes measurement, evaluation, and management systems;
- Have routine reporting processes that are proven to properly support disease management goals;
- Have demonstrable and successful experience in disease management for the targeted disease population;

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13. c. Preventive services/Disease State Management (cont.)

- Provide access to a 24 hour-a-day, seven days-per-week nurse call center;
- Have the ability to guarantee program savings; and
- Meet applicable federal and state laws and regulations governing the participation of providers in the Medicaid program.

Comparability of Services

All clients eligible to participate in the disease management program will receive comparable services, based on their level of disease and co-morbid conditions. All clients will receive be assessed for their risk level, and will receive follow up education and disease management services.

Inclusion Criteria

Target Group: The target group of Medicaid clients eligible to receive Disease Management services are clients who:

(1) Receive medical services through fee-for-service coverage;

(2) Are not institutionalized;

(3) Are high-risk clients with one or more diseases and conditions;

(4) Are not receiving specialized case management services through another program;

(5) Have a primary diagnosis of one of the diseases described in this document.

Enrollment/Disenrollment Process

This disease management program is a voluntary program. All clients in the enrollment group will have access to the toll-free Nurse Advice program. Additionally, those clients with any of the four disease states will be referred to the appropriate DM Vendor for further disease management. Any client may stop participating in the DM program at any time by calling the Disease Management vendor with whom the client is participating, or by calling the State's toll-free customer service line. This process is referred to as "opting out" of the Disease Management Program.

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13. c. Preventive services/Disease State Management (cont.)

Clients may also re-enroll ("opt in") in the Disease Management Program at any time by calling the appropriate disease management vendor, or the State's toll-free customer service line.

Payment methodology for the Programs

In accordance with federal interpretation, the disease management risk contracts. See attachment 4.19-B, IX, G for payment methodology.

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13. d. Rehabilitative services

(1) Physical medicine and rehabilitation as requested and approved.

(2) Alcohol detoxification is limited to three days in certified facilities which are:

(a) Within the physical location and the administrative control of a general hospital; or

(b) Freestanding facilities established to provide this service.

(3) Drug detoxification is limited to five days in certified facilities which are:

(a) Within the physical location and the administrative control of a general - hospital;

(b) Freestanding facilities established to provide this service.

(4) Adult day health is a supervised daytime program providing nursing and rehabilitative-therapy services. Adult day health services are only appropriate for adults with medical or disabling conditions that require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's physician.

(5) Chemical dependency treatment provided in certified programs that include:

(a) Outpatient treatment programs; and

(b) Treatment services, excluding board and room, provided in residential treatment facilities with 16 beds or less.

(6) Medical services furnished by a school district:

(a) Including evaluation, screening and assessment component for those students under consideration for an Individual Education Program or Individualized Family Service Plan; or

(b) Identified as part of a handicapped child s Individual Education Program or Individualized Family Service Plan.

Services to be provided will be physical therapy, speech therapy, occupational therapy, audiology, psychological services, counseling, and nurse services. Licensed/ classified personnel will provide services.

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13. d. Rehabilitative services (cont.)

7. Mental Health Rehabilitation services are integrated treatment services recommended by a mental health professional furnished by state licensed Community Mental Health Agencies. Services are provided to seriously mentally ill adults and seriously emotionally disturbed children for whom the services are determined to be medically necessary. These services must be provided to reach the goals of an Individualized Service Plan. The payment rates are established per Attachment 4.19-B XVII.

The services to be provided are:

- Brief Intervention Treatment;
- Crisis services;
- Day Support;
- Family treatment;
- Freestanding Evaluation and Treatment;
- Group treatment services;
- High Intensity Treatment;
- Individual Treatment Services;
- Intake evaluation;
- Medication Management;
- Medication Monitoring;
- Mental Health Services provided in Residential settings;
- Peer Support;
- Psychological Assessment;
- Rehabilitation Case Management;
- Special population evaluation;
- Stabilization Services; and,
- Therapeutic psychoeducation.

A. Definition of medical necessity as it relates to mental health services

Medical necessity or *medically necessary* – “A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause of physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this chapter "course of treatment" may include mere observation, or where appropriate, no treatment at all.

Additionally, the individual must be determined to 1) have a mental illness covered by Washington State for public mental health services; 2) the individual’s impairment(s) and corresponding need(s) must be the result of a mental illness;

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13. d. 7 Rehabilitative services/Mental health services (cont.)

3) the intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness; 4) the individual is expected to benefit from the intervention; and 5) any other formal or informal system or support can not address the individual's unmet need.

Medical necessity is determined by a mental health professional. All state plan modality services are accessible based on clinical assessment, medical necessity and individual need. Individuals will develop with their mental health care provider an appropriate individual service plan. The services are provided by Community Mental Health Agencies licensed or certified by the Mental Health Division and provided by, or under the supervision of, a mental health professional. Services are assured in accordance with 1902(a)(23).

The following is a descriptive list of the employees or contracted staff of community mental health agencies providing care.

(1) *Mental health professional* means:

(A) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapter 71.05 and 71.34 RCW;

(B) A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;

(C) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.

(D) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or

(E) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-265.

Within the definition above are the following:

"Psychiatrist" means a person having a license as a physician in this state who has completed residency training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and is board eligible or board certified in psychiatry.

"Psychologist" means a person who has been licensed as a psychologist pursuant to chapter 18.83 RCW;

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13. d. 7 Rehabilitative services/Mental health services (cont.)

"Social worker" means a person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary;

"Child psychiatrist" means a person having a license as a physician and surgeon in this state, who has had graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

"Psychiatric nurse" means a registered nurse who has a bachelor's degree from an accredited college or university, and who has had, in addition, at least two years experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional. "Psychiatric nurse" shall also mean any other registered nurse who has three years of such experience.

"Counselor" means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee.

(2) *"Mental Health Care Provider"* means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years experience in the mental health or related fields.

(3) *"Peer Counselor"* means the individual who: has self-identified as a consumer or survivor of mental health services; has received specialized training provided/contracted by the Mental Health Division; has passed a written/oral test, which includes both written and oral components of the training; has passed a Washington State background check; has been certified by the Mental Health Division; and is registered as a counselor with the Department of Health.

Peer Counselors must self identify as a consumer or survivor of mental health services. Peer Counselors must demonstrate:

1. That they are well grounded in their own recovery for at least one year;
2. Willingness to a pretest for reading comprehension and language composition; and,
3. Qualities of leadership, including governance, advocacy, creation, implementation or facilitation of peer-to-peer groups or activities.

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13. d. 7 Rehabilitative services/Mental health services (cont.)

Peer Counselors must be able to:

- Identify services and activities that promote recovery by instilling hope and experiences which lead to meaning and purpose, and which decrease stigma in the environments in which they serve;
- Articulate points in their own recovery stories that are relevant to the obstacles faced by consumers of mental health services;
- Promote personal responsibility for recovery as the individual consumer or mental health services defines recovery;
- Implement recovery practices in the broad arena of mental health services delivery system;
- Provide a wide range of tasks to assist consumers in regaining control over their own lives and recovery process (e.g., promoting socialization, self advocacy, developing natural supports stable living arrangements, education, supported employment);
- Serve as a consumer advocate;
- Provide consumer information and peer support in a range of settings; and,
- Model competency in recovery and ongoing coping skills.

The training provided/contracted by the mental health division shall be focused on the principles and concepts of recovery and how this differs from the medical model, the creation of self-help and coping skills and advocacy. Training will include:

- Understanding the public mental health system;
- What is peer support and how it promotes recovery;
- How to advocate for age appropriate peer support projects;
- How to facilitate groups and teams;
- Understanding self-directed recovery;
- How to create your own self-help coping skills plan;
- How to start and sustain self-help/mutual support groups;
- How to form and sustain a personal support team;
- How to promote recovery, self-determination and community reintegration;
- Assist consumers to do for themselves and each other;
- Assist in skill building, goal setting, problem solving;
- Assist consumers to build their own self-directed recovery tools; and,
- Assist consumers by supporting them in the development of an individual service plan that has recovery goals and specific steps to attain each goal.

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13. d. 7 Rehabilitative services/Mental health services (cont.)

Peer Counselors who were trained prior to the implementation of the Washington Administrative Code by National Consultants to be Certified facilitators who pass the test and the background check, and are registered counselors may be grandfathered as Peer counselors until January 2005. After January 2005, it will be necessary for them to take the training.

(4) *"Registered nurse"* means a person licensed to practice registered nursing under chapter 18.79 RCW.

(5) *"Nurse practitioner"* means a person licensed to practice advanced registered nursing under chapter 18.79 RCW.

(6) *"Licensed practical nurse"* means a person licensed to practice practical nursing under chapter 18.79 RCW.

(7). *"Mental health specialist"* means:

(1) A "*child mental health specialist*" is defined as a mental health professional with the following education and experience:
(a) A minimum of one hundred actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and
(b) The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

(2) A "*geriatric mental health specialist*" is defined as a mental health professional who has the following education and experience:
(a) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of persons sixty years of age or older; and
(b) The equivalent of one year of full-time experience in the treatment of persons sixty years of age or older, under the supervision of a geriatric mental health specialist.

(3) An "*ethnic minority mental health specialist*" is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and
(a) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or

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13. d. 7 Rehabilitative services/Mental health services (continued)

(b) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minority consumers.

(4) A "*disability mental health specialist*" is defined as a mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, "disabled" means an individual with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.
(a) If the consumer is deaf, the specialist must be a mental health professional with:
(i) Knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and
(ii) Ability to communicate fluently in the preferred language system of the consumer.
(b) The specialist for consumers with developmental disabilities must be a mental health professional who:
(i) Has at least one year's experience working with people with developmental disabilities; or
(ii) Is a developmental disabilities professional as defined in RCW 71.05.020.

Staff Supervision means monitoring the administrative, clinical or clerical work performance of staff, students, interns, volunteers or contracted employees by persons with the authority to direct employment activities and require change. When supervision is clinical in nature, it shall occur regularly and may be provided without the consumer present or may include direct observation of the delivery of clinical care. Supervisory activities include the review of all aspects of clinical care including but not limited to review of assessment, diagnostic formulation, treatment planning, progress toward completion of care, identification of barriers to care, continuation of service and authorization of care.

B. DEFINITIONS

(1) *Brief Intervention Treatment:* Solution focused and outcomes oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment.

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13. d. 7 Rehabilitative services/Mental health services (cont.)

Functional problems and/or needs identified in the Medicaid enrollee's Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee's current level of functioning and assistance with self/care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

(2) *Crisis Services:* Evaluation and treatment of mental health crisis to all Medicaid enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

(3) *Day Support:* An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

(4) *Family Treatment:* Psychological counseling provided for the direct benefit of a Medicaid enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants.

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13. d. 7 Rehabilitative services/Mental health services (cont.)

Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their individual service plan. This service is provided by or under the supervision of a mental health professional.

(5) *"Freestanding Evaluation and Treatment"* Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to the Medicaid enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to, performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder.

The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow them to be managed at a lesser level of care. This service does not include cost for room and board.

The Mental Health Division must authorize exceptions for involuntary length of stay beyond a fourteen-day commitment.

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13. d. 7 Rehabilitative services/Mental health services (cont.)

(6) *Group Treatment Services:* Services provided to Medicaid enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more Medicaid enrolled individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

(7) *High Intensity Treatment:* Intensive levels of service otherwise furnished under this state plan amendment that is provided to Medicaid enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual's need. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, neighbor). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*, etc. Team members work together to provide intensive coordinated and integrated treatment as described in the individual service plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the individual service plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

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13. d. 7 Rehabilitative services/Mental health services (cont.)

Billable components of this modality include time spent by the mental health professionals, mental health care providers and peer counselors.
*Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality.

(8) *Individual Treatment Services:* A set of treatment services designed to help a Medicaid enrolled individual attain goals as prescribed in their individual treatment plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include, developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid enrolled individual. This service is provided by or under the supervision of a mental health professional.

(9) *Intake Evaluation:* An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a mental health professional.

(10) *Medication Management:* The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.

(11) *Medication Monitoring*: Face-to-face one-on-one cueing, observing, and encouraging a Medicaid enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional. Time spent with the enrollee is the only direct service billable component of this modality.

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13. d. 7 Rehabilitative services/Mental health services (cont.)

(12) *Mental Health Services provided in Residential Settings*: A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid enrolled individuals receiving this service present with severe impairment in psychosocial functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment.

The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

(13) *Peer Support:* Services provided by peer counselors to Medicaid enrolled individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumers' ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc). Drop-in centers are required to maintain a log documenting identification of the consumer including Medicaid eligibility.

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13. d. 7 Rehabilitative services/Mental health services (cont.)

Services provided by peer counselors to the consumer are noted in the consumer's Individualized Service Plan which delineates specific goals that are flexible tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, and indicates where treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available daily no more than four hours per day. The ratio for this service is no more than 1:20.

(14) *Psychological Assessment:* All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumer's continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

(15) *Rehabilitation Case Management:* A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage, to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned read mission and to increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

(16) *Special Population Evaluation:* evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

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13. d. 7. Rehabilitative services/Mental health services (cont.)

(17) *Stabilization Services:* Services provided to Medicaid enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

(18) *Therapeutic Psychoeducation:* Informational and experiential services designed to aid Medicaid enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plan of care. These services are exclusively for the benefit of the Medicaid enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional. Classroom style teaching, family treatment, and individual treatment are not billable components of this service.

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13. d. 8. Therapeutic child-care

Therapeutic child-care to treat psycho-social disorders in children under 21 years of age based on medical necessity. Services Include: developmental assessment using recognized, standardized instruments play therapy; behavior modification; individual counseling; self esteem building; and family intervention to modify parenting behavior and/or the child's environment to eliminate/prevent the child's dysfunctional behavior. Prior approval is required. Payment rates are established per section X of Attachment 4.19-B.

Line staff, responsible or planning and providing these services in a developmentally appropriate manner must have an AA degree in Early Childhood Education or Child-Development or related studies, plus five years' of related experience, including identification, reporting, and prevention of child abuse and/or neglect.

Supervisory staff must have a BA in Social Work or related studies, plus experience working with parents and children at risk of child abuse and/or neglect. Experience can be substituted for education using a 2:1 ratio. Their responsibilities are for development, implementation and documentation of treatment plans for each child.

Agencies and individual providers must be approved as meeting Medicaid agency criteria and certification requirements under state law as appropriate.

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13. d. 9. Behavior Rehabilitation Services.

Behavior rehabilitative are services provided to children to remediate debilitating disorders, upon the certification of a physician or other licensed practitioner of the healing arts within the scope of their practice within state law. Prior approval is required.

Service Description

Specific services include milieu therapy, crisis counseling and regularly scheduled counseling and therapy, as well as medical treatment.

Milieu therapy refers to those activities performed with children to normalize their psycho-social development and promote the safety of the child and stabilize their environment. The child is monitored in structured activities which may be recreational, rehabilitative, academic, or a variety of productive work activities. As the child is monitored, intervention is provided to remediate the dysfunctional behaviors and encourage appropriate responses in a broad range of settings.

Crisis counseling is available on a 24 hour basis, providing immediate short term intervention to assist the child in responding to the crisis and/or stabilize the child's behavior until problems can be addressed in regularly scheduled counseling and therapy sessions.

Regularly scheduled counseling and therapy, as well as psychological testing, is provided. The purpose of which is to remediate specific dysfunctions which have been explicitly identified in a continually updated formal treatment plan. Therapy may be in an individual or group setting. It may be directed toward the child alone, the child within his/her biological or the adopted family, or the child within his/her peer group.

Medical treatment may also be provided. Twenty-four hour nursing is provided for children who are medically compromised to such an extent that they are temporarily unable to administer self care and are impaired medically/developmentally immediate the caretaker's ability to provide medical/remedial care.

Population to be Served

Children who receive these services suffer from developmental disabilities and behavioral/emotional disorders that prevent them from functioning normally in their homes, schools, and communities. They exhibit such symptoms as drug and alcohol abuse; anti-social behaviors that require an inordinate amount of intervention and structure; sexual behavior problems; victims of severe family conflict; behavioral disturbances often resulting from psychiatric disorders of the

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13. d. 9. Behavior Rehabilitation Services (cont.)

parents; medically compromised and developmentally disabled children who are not otherwise served by the state agency's Division of Developmental psychological Disabilities; and impairments.

Provider Qualifications

Service include Social Staff: Responsibilities development of service plans; individual, group, and family counseling; and assistance to child care staff in providing appropriate treatment for clients. The minimum qualification is a Masters Degree in social work or a closely allied field.

Child Care Staff: Responsibilities include assisting social service staff in providing individual, group, and family counseling; and therapeutic intervention to address behavioral and emotional problems as they arise.

Minimum qualifications require that no less than 50% of the childcare staff in a facility have a Bachelors Degree. Combinations of formal education and experience working with troubled children may be substituted for a Bachelor's degree.

Program Coordinator: Responsibilities include supervising staff, providing overall direction to the program and assuring that contractual requirements and intents are met.

Minimum qualifications are to be at least 21 years of age with a Bachelors Degree, preferably with major in study psychology, sociology, social work, social sciences, or a closely allied field, and two years experience in the supervision and management of the group care program for adolescents.

Counselor: Responsibilities include case planning, individual and group counseling, assistance to child care staff in providing appropriate treatment for clients, coordination with other agencies, and documentation of client progress.

Minimum qualifications are to be at least 21 years of age possessing a Master's Degree with major study in social one year work or a closely allied field and of experience in the care of troubled adolescents or, a Bachelor's Degree with major study in social work, psychology, and experience in the care of troubled adolescents.

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17. Nurse midwife services

Limited to facilities approved by the department to provide this services, or in the case of home births, to clients and residences approved for this service. To participate in home births, midwives must be a MAA-approved provider.

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18. Hospice care (in accordance with section 1903(o) of the Act.)

Also includes pediatric palliative care services that are provided for approved clients 20 years old and younger who have a life limiting diagnosis.

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20. Extended services for pregnant women, through the sixty days postpartum period. The extended services include:

a. Maternity support services, by a provider approved by the Department of Health and the department, consisting of:

(1) Nursing assessment and/or counseling visits;
(2) Psychosocial assessment and/or counseling visits;
(3) Nutrition assessment and/or counseling visit;
(4) Community health worker visit; and
(5) Child birth education.

b. Outpatient alcohol and drug treatment for pregnant and postpartum women consisting of a chemical dependency assessment by an Alcohol and Drug Abuse Treatment and Services Act assessment center, parenting education, and chemical dependency treatment.

c. Rehabilitation alcohol and drug treatment services, excluding room and board, for pregnant and postpartum women recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under State law. Services are provided in residential treatment facilities with 16 beds or less certified by the Division of Alcohol and Substance Abuse.

d. Genetic counseling performed by a provider approved by Parent-Child Health Services and the department.

e. Smoking cessation counseling, up to ten sessions, to include the following:

(1) Assessing the pregnant and postpartum woman's tobacco dependence;
(2) Providing advice and assistance, including a written smoking cessation plan; and
(3) If appropriate, prescribing smoking cessation pharmacotherapy, as needed.

Smoking cessation counseling may be provided by physicians, advanced registered nurse practitioners, licensed midwives, and physician assistants.

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22. Respiratory care services

As defined in rule, the department covers medically necessary oxygen and/or respiratory therapy equipment, supplies and services to eligible clients in nursing facilities, community residential settings, and in their homes. The above is prescribed by a health care practitioner authorized by law or rule in the State of Washington. Prior authorization is required for specified equipment, or when a request falls outside of the defined criteria.

Selected contracted nursing facilities are authorized to provide exceptional care needs to ventilator- and tracheostomy-dependent clients.

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24. a. Transportation

(1) Ambulance transportation is provided as an optional service for emergencies or as required by state law.

(2) All non-emergency transportation services, to assure clients have access to and from covered services, are provided using administrative matched dollars in accordance with Section 42 CFR 431.53, and are not considered a medical service described in the coverage section of the State Plan.

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24. d. Nursing facility services for patients under 21 years of age

The admission requires prior approval.

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25. Home and community care for functionally disabled elderly Individuals, as defined, described and limited in Supplement 2 to attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A

Provided
__X__ Not provided

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26. Personal care services

a. Eligibility for services.

Persons must living in their own home, Adult Family Home, family foster home, children's group care facility or licensed boarding home.

b. Persons must be determined to be categorically needy and have three ADL needs requiring minimal assistance or one ADL need requiring more than minimal assistance. ADL assistance is defined in WAC 388-71-0202 and WAC 388-72A-0035 and WAC 388-72A-0040.

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27. An alien who is a non-qualified alien or a qualified alien subject to the five-year ban and is otherwise eligible for Medicaid is eligible only for care and services necessary to treat an emergency medical condition as defined in section 1903(v) of the Act.

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28. Program of all-inclusive care for the elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A

_X_ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

___ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

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HIV/AIDS CASE MANAGEMENT SERVICES

A. Target Group:

Clients who have a current medical diagnosis of HIV or AIDS and who are eligible for Title XIX (Medicaid) coverage under the Categorically Needy Program (CNP) or the Medically Needy Program (MNP). The clients require assistance obtaining and effectively using necessary medical, social, and educational services or the client's condition is such the client requires 90 days continued monitoring.

B. Areas of State in which services will be provided:

/X/ Entire State.

/ / Only in the following geographic areas (authority of section 1915 (g) (1)) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services:

/ / Services are provided in accordance with section 1902 (a) (10) (B) of the act.

/X/ Services are not comparable in amount, duration, and scope. Authority of section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a) (10) (B) of the Act.

D. Definition of Services

MAA requires that HIV/AIDS case management providers perform the following functions:

1. Notify HIV positive persons, verbally or by signing a statement, of their choice of available HIV/AIDS case management providers statewide. This requirement does not obligate HIV/AIDS case management

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HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

D. Definition of Services (continued)

providers to accept all clients who request their services. The case management provider will refer the client to another provider.

2. Obtain and maintain a current Authorization to Release/Obtain Information form. The provider must have a valid authorization on file for the months that case management services are billed to MAA. The provider cannot charge the client for services or documents related to covered services.

3. Maintain sufficient contact to ensure effectiveness of ongoing services. MAA requires a minimum of one contact per month between the HIVIAIDS case manager and the client. However, contact frequency must be sufficient to ensure implementation and ongoing maintenance of the Individual Service Plan (ISP).

Case management includes services which will assist clients in: living as independently as possible, maintaining and improving their health, reducing behaviors that put themselves and others at risk, and gaining access to needed medical, social, and educational services.

Description of Services:

Case management functions (core and support) are provided under the direction of a qualified case manager and are detailed below.

Core Functions:

Comprehensive Assessment: A comprehensive assessment is an evaluation to determine client's needs for case management services in several areas. This evaluation includes demographic information, physical status, HIV diagnosis, psychological/social/cognitive functioning and mental health history, ability to perform daily activities, financial and employment status, medical benefits and insurance coverage, informal support systems, legal status, and reportable behaviors which could lead to HIV transmission or reinfection.

Service Plan Development: An individual service plan must be developed in conjunction with the comprehensive assessment to identify and document the client's unmet needs and the resources needed to assist in meeting those needs.

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HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

D. Definition of Services, Core Functions (cont.)

Service Plan Implementation: The case manager is responsible for implementation of the service plan, but may delegate specific functions to others, such as the home health nurse, discharge planners, etc.

Service Plan Review: The case manager must review the service plan monthly through in-person contact or by telephone contact with the client.

Narrative Records: Case managers must keep ongoing records, which clearly document case management services. These records must include the reason for the case manager's interaction with the client and the plans in place or to be developed to meet unmet client needs.

Support Functions:

Client Advocacy: Intervene with agencies or persons to help individual clients receive appropriate benefits or services.

Assistance: Assist or arrange for the client to obtain a needed service or accomplish a necessary task.

Consultation: Consult with service providers and professionals to utilize their expertise on the client's behalf.

Networking: Help a client to access services through linkages between formal and informal support systems for the purpose of creating an effective continuum of care.

Family Support: Arrange for appropriate referrals to help the family or significant others to deal with stress and changes related to the client's impairments.

E. Qualifications of Providers:

Provider Qualifications - Individual case managers

An HIV/AIDS case manager shall:

1. Be either a professional or a paraprofessional (HIV/AIDS case manager assistant) under the direct supervision of a professional;

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HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

E. Qualifications of Providers (continued)

2. Be employed and enrolled as an HIV/AIDS case manager by a public or private health, social service, or education agency.

3. Have demonstrated skills and knowledge necessary to perform his/her job responsibilities at the time of employment or have the potential of achieving the required skills and knowledge through training;

4. Have a general knowledge of HIV/AIDS-related conditions and diseases, the AIDSNET service delivery system, and other service delivery systems in his/her community;

5. Meet at least the following requirements for education and experience:

(a) Master's Degree in behavioral or health sciences (e.g. social work, clinical psychology, sociology, guidance counseling, nursing, and public health) and one year of paid social service experience;

(b) Bachelor's Degree in behavioral or health sciences and two years of paid social services experience;

(c) Bachelor's Degree and three years of paid social services experience.

HIV Client Services, Department of Health may make exceptions to the above requirements when the service population is geographically or culturally isolated, or has limited English speaking ability.

Provider qualification - Case management agencies

An HIV/AIDS case management agency must:

1. Be a public or private social service, health, or education agency employing staff with HIV/AIDS case manager qualifications;

2. Demonstrate linkage and referral ability with social and health service agencies and individual practitioners;

3. Have experience working with persons living with HIV/AIDS;

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HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

E. Qualifications of Providers (continued)

4. Meet applicable state and federal laws and regulations governing the participation of providers in the Medicaid program;

5. Have caseload size standards that allow HIV/AIDS case management staff to perform the duties established in the Title XIX HIV/AIDS case management standards;

6. Have supervisors who meet the HIV/AIDS case manager qualifications and have:

(a) A Master's Degree and two years of paid social service experience; or

(b) A Bachelor's Degree and three years of paid social service experience, including one supervisory year.

F. Choice of Providers

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act. Eligible recipients will have free choice of the providers of:

1. HIVIAIDS case management services; and

2. Other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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II. VULNERABLE ADULTS

1915(g)(1) TARGET POPULATION

Recipients age 18 and over who:

a) Require services from multiple health/social service providers; and,

b) Are unable to obtain the required health/social services for themselves; and,

c) Do not have family or friends who are able and willing to provide the necessary assistance; and,

d) Have at least minimal need for assistance with one or more activities of daily living. 1915 (g) (1) STATEWIDENESS

This service will be offered on a statewide basis.

1915(g)(1) COMPARABILITY
1902 (a) (1)

In accord with Section 1915(g)(1), case management services will be provided without regard to the requirements of Section 1902(a)(10)(B) of the act. Services will be provided to all recipients age 18 and over.

1915(g)(1) FREEDOM OF CHOICE
1902 (a) (23

In accord with Section 1902(a)(23) of the Social Security Act, individuals eligible to receive medical services shall be free to obtain such services from any institution, agency or person qualified to provide services available under the Medical Assistance program.

1915 (g) (2) DEFINITION OF SERVICE

Case management means services which will assist individuals eligible under the plan in gaining access to needed health and related social services.

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(Case Management, Vulnerable Adults, cont)

DESCRIPTION OF SERVICE:

Required services include screening and referral as well as comprehensive assessment of individual needs and development of detailed individual plans of service and related activities. The plan is designed to assist clients to obtain needed health-related services in the least restrictive service setting. Case management functions are provided under the direction of a qualified case manager and may be divided into core functions and support, functions.

Core Functions:

Intake Evaluation: A comprehensive assessment to determine a client's need for case management and/or other services.

Service Plan Development: An individual case management service plan is developed when the client has been determined to meet target population criteria.

Service Plan Implementation: The case manager is responsible or implementation of the service plan, but may delegate specific functions to others. Service plan implementation includes counseling to encourage client cooperation in implementing the service plan, service authorization when appropriate, referral for services, case coordination and maintaining regular contact with the client to carry out the service plan.

Service Plan Review: Service plan reviews will be conducted as needed and always in person.

Termination Planning: The case manager is responsible or planning to terminate case management services when the client's situation has stabilized.

Support Functions:

Client Advocacy: Intervene with agencies or persons to help individual clients receive appropriate benefits or services.

Assistance: Help the client obtain a needed service or accomplish a necessary task (complete a form, obtain appropriate authorization, find a living situation, help with moving, provide transportation or escort, etc.)

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(Case Management, Vulnerable Adults, cont)

Description of Service (cont.)

Consultation: Consult with service providers and professionals to utilize their expertise on the client's behalf.

Networking: Develop a series of linkages between formal and informal support systems for the purpose of creating an effective continuum of care.

Crisis Intervention: Provide short-term intervention in an emergency situation.

PROVIDERS:

Services will be provided by qualified case managers who meet the case management standards promulgated by the Division of Medical Assistance. The Division of Medical Assistance will assure freedom of choice of providers to eligible clients.

QUALIFICATIONS:

Case Managers will meet at least the following requirements for education and experience:

1. Master's Degree in behavioral or health sciences and one year of paid on-the-job social service experience;

OR

2. Bachelor's Degree in behavioral or health sciences and two years of paid on-the-job social service experience;

OR

3. Bachelor's Degree and four years of paid on-the-job social service experience.

Exceptions to qualification requirements will be granted by the Division of Medical Assistance when the population to be served is:

1. Of limited-English speaking ability or is culturally isolated and access is assured by hiring bilingual bicultural staff;

OR

2. Geographically isolated.

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(Case Management, Vulnerable Adults, cont)

It is the intent of this policy that exceptions will be rare.

Case managers qualifying under these circumstances will be designated as case manager trainees. Case manager trainees will participate in on-the-job training. Their supervisor must review and provide follow-up on all cases managed by the trainee each month. At the end of three years, the trainee will be evaluated by the supervisor; if his or her work meets the standards required, he/she will move to regular case manager status.

RELATION TO STATE AGENCY:

In accordance with the Title XIX State Plan, responsibility for administration will be with the Single State Agency. Discrete functions may be delegated to other agencies, but only under formal, written agreements.

ASSURANCES

1915(b) (c) NON-DUPLICATION OF OTHER CASE MANAGEMENT SERVICES

Payments made for targeted case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

The Division of Medical Assistance will maintain an adequate audit trail to ensure that match is non-federal in origin and that billed services were actually delivered.

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INFANT CASE MANAGEMENT SERVICES
(formerly Maternity Case Management Services)

A. Target Group:

The Department serves infants who are Medicaid clients and who meet high-risk criteria from three months of age through the month of the infant's first birthday. A high-risk infant:

1. Meets at least one of the following eligibility criteria:

a. Staff concern for the parent's ability to care for infant specifically due to at least one of the following:

- Incarceration of the mother within the last year
- Low functioning of the infant's parent(s) (as demonstrated by examples such as: needs repeated instructions; not attuned to infant cues; leaves infant with inappropriate coregivers; parent has the equivalent of less than an 8th grade education,)
- Mental health issue of the parent(s) that is not stabilized (issue treated or untreated)
- Physical impairment of the infant's parent
- Infant's mother is experiencing post pregnancy depressiona or mood disorder **OR** has a history of depression/mood disorder
- In ability to access rexources due to age: 19 years old or younger
- Social isolation (as demonstrated by examples such as: family is new to the communityl; parent(s) does not have a support system; family moves frequently; lack of supportive living enbironment)_
- Inability to access resources due to language or cultural barrier (as demonstrated by examples such as: speaks only Mixteco; recently arrived from Guatemala and speaks no English; recently arrived from Mexido and is having difficulty navigating health care system)
-

-OR-

b. Staff concern for the safety of nfant specifically due to at least one of the following:

- Domestic or family violence in present or past relationship which keep the parent feeling unsafe
- Substance abuse by the infant's mother and/or father that is impacting ability to parent
- Secondhand smoke exposure to the infant
- CPS involvement within the last year **OR** mother/father had parental rights terminated in the past

-OR-

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Infant Case Management Services (cont.)

- Unstable living situation (as demonstrated by examples such as: homelessness; couch surfing; unsafe conditions; no cooking facilities, heat or water)

-OR-

c. Staff concern for infant health needs specifically due to at least one of the following:

- LBW (low birth weight - less than 5.5 pounds)
- Premature birth (less than 37 weeks gestation)
- Failure to thrive (as demonstrated by examples such as: baby is not gaining weight; significant feeding difficulty; no eye contact; baby is listless)
- Multiple birth (twins or more infants)
- Excessive fussiness or infant has irregular sleeping patterns (as demonstrated by examples such as: parent(s)' sleep deprivation, exhaustion and/or need for respite childcare)
- Infant has an identified medical problem or disability

2. Infant's parent(s) demonstrates need for a case manager's assistance in accessing medical services or other social and health services.

3. Title XIX targeted case management services may not be duplicated. This is clearly explained in the ICM Billing Instructions and training materials furnished to providers. If the high-risk infant and family are involved in services for another targeted group, ICM is closed and case management for the other targeted group is initiated.

B. Areas of state in which services will be provided:

[X] Entire State

[ ] Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide.)

C. Comparability of services:

[ ] Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

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State WASHINGTON

Infant Case Management Services (cont.)

D. Definition of Services:

Infant case management is an ongoing process to assist eligible clients in gaining access to and effectively using necessary medical, educational, social and other services.

The core functions of the case manager are to provide or assist in providing:

Assessment: This component includes activities that focus on needs identification. Activities include assessment of an eligible individual to determine the need for any medical, educational, social, and other services. Specific assessment activities include: taking client history, identifying the needs of the individual, and completing related documentation. It also includes gathering information from other sources such as family members, medical providers, and educators, if necessary, to form a complete assessment of the Medicaid eligible individual.

Care Planning: This component builds on the information collected through the assessment phase and includes activities such as ensuring the active participation of the Medicaid eligible individual and working with the individual and others to develop goals and identify a course of action to respond to the assessed needs of the Medicaid eligible individual. The goals and actions in the care plan should address medical, social, educational, and other services needed by the Medicaid eligible individual.

Referral & Linkage: This component includes activities that help link Medicaid eligible individuals with medical, social, and educational providers and/or other programs and services that are capable of providing needed services. For example, making referrals to providers for needed services and scheduling appointments may be considered case management.

Monitoring/Follow-up: This component includes activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the Medicaid eligible individual. The activities and contact may be with the Medicaid eligible individual, family members, providers, or other entities. These may be as frequent as necessary to help determine such things as (i) whether services are being furnished in accordance with a Medicaid eligible individual's care plan, (ii) the adequacy of the services in the care plan, and (iii) changes in the needs or status of the Medicaid eligible individual. This function includes making necessary adjustments in the care plan and service arrangements with providers.

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State WASHINGTON

Infant Case Management Services (cont.)

E. Qualifications of Providers: The Medical Assistance Administration will assign Medical Provider Numbers to the following for the provision of Case Management services:

1. Infant Case Managers

a. A case manager will be either a professional or a paraprofessional under the direct supervision of a professional.

b. Case managers will have a minimum level of work-related experience involving contact with the public in a client service setting as outlined in the Qualifications below.

- A current professional of the integrated Maternity Support Services team (i.e., community health nurse, behavioral ealth specialist, and nutritionist).

-OR-

- A person with a Bachelor's (or Master's) degree in social service-related field such as: social work, behavioral sciences, psychology, child development, certified home and family life teacher, mental health counselor **plus** one year of experience working in community social services, public health services, crisis intervention, outreach and linkage program or other related field.

-OR-

- A paraprofessional with a two-year Associate of Arts (AA) degree in social services **and** two years of full time experience in community social services or related field. This staff person must receive monthly clinical supervision by a BA or Master's prepared person.

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Infant Case Management Services (cont.)

F. Case Management Agencies:

a. Public or private social, health or education agencies employing staff with case manager qualifications.

b. Demonstrate linkages and referral ability with essential social and health agencies and individual practitioners.

c. Have experience working with low-income families, especially regnant and parenting women and children.

d. Meet applicable state and federal laws and regulations governing the participation of providers in the Medicaid program.

G. The state assures that there are no restrictions on a client's free choice of Providers in violation of Section 1902 (a) (23) of the Act.

a. Eligible clients will have free choice to receive or not receive infant case management services.

b. Eligible clients have free choice of the providers of infant case management.

c. Eligible clients have free choice of the providers of other medical care under the plan.

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State WASHINGTON

CASE MANAGEMENT SERVICES

A. Target Group:

All Medicaid recipients under age 21 whose family or caretaker needs assistance in accessing necessary medical, social, educational, and other services.

B. Areas of State in which services will be provided:

/X/ Entire State

This service will be offered on a statewide basis as service delivery systems are developed and become available.

C. Comparability of Services:

/X/ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Case management is an ongoing process to assist the recipient(s) to obtain and effectively utilize necessary medical, social, educational and other services.

Description of Service:

Core Functions: The core functions of the case manager are to provide or assist in providing:

Linkage: Help recipient(s) to access services through linkages between support systems to avoid duplication of services. Identify recipient needs in physical, environmental, psychosocial, developmental, educational, behavioral, emotional, and mobility areas.

Planning: Prepare a service plan that reflects the recipient's need as identified through the assessment process.

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State WASHINGTON

(Case Management, Under Age 21, cont)

Implementation: Assure that the recipients) receives services as indicated in the service, plan and regular contacts to encourage cooperation, and resolve problems which may create barriers.

Advocacy: Assist the recipient(s) to follow through on recommendations.

Accountability: Retain documentation of case management services provided. Submit data as required.

E. Any qualified provider may contract with DCFS, which is a unit within DSHS, the single state Medicaid agency.

1. Case Managers

a. A case manager will be either a professional or a paraprofessional under the direct supervision of a professional.

b. Case managers will have a minimum of one year of on-the-job experience involving contact with the public in a client-service setting.

c. In addition, the following are the specific minimum requirements for each category of case managers:

(1) Nurse - B.S.N. with course work in public health; or a registered nurse with two years of experience in parent-child nursing.

(2) Social service worker - Master's Degree in Social Work in Behavioral Science or related, field, with one year of experience in community social services or public health services or related field. Other Master's or, Bachelor's Degree may be substituted with two years closely-related work experience in community social services, public health services, or related field.

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State WASHINGTON

(Case Management, Under Age 21, cont)

(3) Certificated teachers - Specialized training and experience in parenting education, child development, nutrition, family resource management, health, intervention, and one year on-the-job experience.

(4) Educational Staff Associate - Certification as a school counselor, school psychologist, school nurse, school social worker, or physical or speech or occupational therapist and one year on-the-job experience.

(5) Substance Abuse Counselor - Meet the requirements of a Qualified or Certified Counselor as defined in WAC 275-19-145(1) and one year on-the-job experience.

(6) Paraprofessional - Under direct supervision of a registered nurse or social service worker case management provider, a paraprofessional may conduct case management activities. Associate Degree in Behavioral Health Sciences related field and two years of closely related work experience. Two additional years of appropriate experience could be substituted for the degree.

d. Foster parents may not serve as case managers for foster children.

2. Case Management Agencies

a. Public or private social, health or education agencies employing staff with case manager qualifications. This includes state DSHS staff.

b. Demonstrate linkages and referral ability with essential social and health service agencies and individual practitioners.

c. Has experience working with low-income families, especially children.

d. Meets applicable federal and state laws and regulations governing the participation of providers in the Medicaid program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

(Case Management, Under Age 21, cont)

F. The state assures that there will be no restrictions on a recipient's free choice of providers in violation of Section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice to receive or not receive case management services.

2. Eligible recipients will have free choice of the providers of case management services.

3. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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CASE MANAGEMENT SERVICES

A. Targeted Population:

Title XIX eligible individuals who:

(1) Are Limited English Speaking (LES); and

(2) Are 16 years of age and over; and

(3) Are refugees or immigrants who lack English proficiency, are unable to access information or obtain assistance, or a job in order to become economically independent; and

(4) Require services from multiple health/social service providers; and

(5) Are unable to obtain the required health/social services for themselves; and

(6) Do not have family or friends who are able and willing to provide the necessary assistance.

16 to 18 year old clients will only be served if these services are not available through the public school system and or the Superintendent of Public Instruction Office.

B. Areas of State in which services will be provided:

X Entire State

This service will be offered on a statewide basis.

___ Only in the following geographic areas (authority of section 1915(g)(1)) of the Act is invoked to provide services less than Statewide:

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State WASHINGTON

(Case Management, LES, cont)

C. Comparability of Services:

__ Services are provided in accordance with section 1902 (a) (10) (B) of the Act.

_X_ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a)(10)(B) of the Act.

D. Definition of Service:

Case Management services for limited English speaking clients is an ongoing process designed to assist eligible recipient (s) to obtain and effectively utilize necessary medical, social, educational and other services. Under this plan the Division of Refugee Assistance (DORA) will offer two levels of case management services (1) barriers removal (i.e., assessment, planning and follow-up) and (2) intensive self-sufficiency services and supportive services.

Core Functions:

1. *Comprehensive Assessment and follow up-* This service includes an intake interview and assessment of client's needs for medical, educational, social and other related services deemed appropriate by the case manager. The case manager will prepare a detailed plan of services needed to help the client overcome barriers to self-sufficiency. The focus of this service is client referral and access to needed services. Follow-up on this plan is essential to insure that appropriate services are received.

2. *Self-Sufficiency Service:* This service is provided to inform each client about, and gain access to, needed services, such as health, social and educational opportunities (English as a Second Language (ESL), Vocational Training, etc. ,). Access to services is accomplished by setting, on an individual basis, personal goals for self-sufficiency, and designing realistic plans for the individual client related to access to specific services.

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State WASHINGTON

(Case Management, LES, cont)

Providers will also establish linkages with other organizations to assist the clients with accessing health, social, and education needs.

Support Function:

Client Advocacy: Intervene with agencies or persons to help individual clients receive appropriate benefits or services.

E. Qualification of Providers:

Case management services will be provided through contracts between the Medicaid agency and any provider meeting the below specified qualifications:

1. Case Management Agencies:

   a. Must be a social service agency, employing staff with case management qualifications.

   b. Must be able to provide referral services and demonstrate linkages and referral ability with essential social and health service agencies.

   c. Have a minimum of one year experience in assisting low income families obtain medical, employment training, and other related social service.

2. Case Managers must meet the following requirements for education and experience:

   a. A Bachelor's Degree in social services or an allied field and **one year** of social service experience with refugees and immigrants. **Two years** of social service experience or providing case management services to refugee families may be substituted for two years of the required education.

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(Case Management, LES, cont)

b. Preferably be bilingual (read, write and speak fluently in the client's native language) and/or bicultural (have in-depth knowledge of the client's culture).

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

3. Eligible clients will have the option to participate in the services offered under this plan.

G. Payment for case management services under the plan will not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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CASE MANAGEMENT SERVICES

A. Target Group:

Persons who are Medicaid recipients (clients) and alcohol- or other drug-dependent who need assistance in obtaining necessary medical, social, educational, vocational, and other services.

B. Areas of State in which services will be provided:

/X/ Entire State

C. Comparability of Services:

/X/ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Case management is an ongoing process to assist eligible clients gain access to and effectively use necessary health and related social services.

Description of Services:

Case management will be used to either involve eligible clients in chemical dependency treatment or to support them as they move through stages of chemical dependency treatment within or between separate treatment agencies.

Core Functions: The core functions of the case manager are to provide or assist in providing:

Identification of Needs
Complete a comprehensive and ongoing assessment of the client's needs for medical, social, educational, and other related services. Address the barriers to accessing or utilizing chemical dependency treatment services and other services.

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(Case Management, Alcohol/Drug Dependent, cont)

D. Description of services (con't)

Planning
Prepare and implement a written service plan that reflects the client's needs and the resources available to meet those needs in a coordinated, integrated fashion.

Linkage
Facilitate access to needed services through linkages between support systems to avoid duplication of services. These services will augment/reinforce the treatment for chemical dependency.

Advocacy
Intervene with agencies/persons to help clients receive appropriate benefits or services. Also, help the client obtain a needed service or accomplish a necessary task. Be available to help problem-solve when there is a crisis in the client's treatment plan. Advocate for the client's treatment needs with treatment providers.

Accountability
Retain documentation of case management plan and services provided. Submit data as required.

E. Qualifications of Providers:

Case management services will be provided through contracts between the Medicaid agency and chemical dependency treatment agencies certified under Chapter 388-805 WAC in order to ensure that the case managers for these clients are capable of providing the full range of services needed by these targeted clients.

Case management services will be provided by a Substance Abuse counselor who meets the requirements of a certified Chemical Dependency Professional or a Chemical Dependency Professional Trainee as defined in WAC 388-805.

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(Case Management, Alcohol/Drug Dependent, cont)

F. The state assures that the provision of case management services will not restrict a client's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible clients will have free choice to receive or not receive case management services.

2. Eligible clients will have free choice of the providers of other medical care under the plan.

Payment for case management services under the plan will not duplicate payments made to public agencies or private entities under other program authorities this same purpose.

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES FOR THE CATEGORICALLY NEEDY

1. The State of _____ provides home and community care to functionally disabled elderly individuals to the extent described and defined in this Supplement (and Appendices) in accordance with section 1929 of the Social Security Act.

2. Home and community care services are available Statewide.

_____ Yes _____ No

If no, these services will be available to individuals only in the following geographic areas or political subdivisions of the State (specify):

_____
_____

3. The home and community care services specified in this Supplement will be limited to the following target groups of recipients (specify all restrictions that will apply):

a. _____ Aged (age 65 and older, or greater than age 65 as limited in Appendix B)

b. _____ In accordance with §1929(b)(2)(A) of the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals are specified in Appendix A. Minimum disability standards for these individuals are specified in Appendix B.

c. _____ In accordance with §1929(b)(2)(A) of the Act, individuals who were served under a waiver granted pursuant to section 1915(d) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals are specified in Appendix A. Minimum disability standards for these individuals are specified in Appendix B.

d. _____ In accordance with §1929(b)(2)(B) of the Act, individuals who meet the test of disability under the State's §1115 waiver which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. Financial eligibility standards for these individuals are specified in Appendix A. Functional disability standards for these individuals are specified in Appendix B.

4. Additional targeting restrictions (specify):

a. _____ Eligibility is limited to the following age groups (specify):

_____
_____

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State WASHINGTON

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES FOR THE CATEGORICALLY NEEDY

b. _____ Eligibility is limited by the severity of disease or condition, as specified in Appendix B.

c. _____ Eligibility is limited to individuals who have been shown to have a need for one or more of the services elected by the State under this benefit.

5. Standards for financial eligibility are set forth in Appendix A. Each individual served shall meet applicable standards for financial eligibility.

6. Each individual served will meet the test of functional disability set forth in Appendix B.

7. The State will provide for a comprehensive functional assessment for a financially eligible individual who meets the targeting requirements set forth in item 3 of this Supplement. This assessment will be provided at the request of the individual or another person acting on such individual's behalf. The individual will not be charged a fee for this assessment.

8. The comprehensive functional assessment will be used to determine whether the individual is functionally disabled, as defined in Appendix B. Procedures to ensure the performance of this assessment are specified in Appendix D.

9. The comprehensive functional assessment is based on the uniform minimum data set specified by the Secretary. Check one:

   a. _____ The State will use the assessment instrument designed by HCFA.

   b. _____ The State will use an assessment instrument of its own designation. The assessment instrument to be used is consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by HCFA. A copy of the assessment instrument can be found at Appendix D.

10. The comprehensive functional assessment will be reviewed and revised .not less often than every 12 months. Procedures to ensure this review and revision are specified in Appendix D.

11. The comprehensive functional assessment and review will be conducted by an interdisciplinary team designated by the State. Qualifications of the interdisciplinary team are specified in Appendix D.

12. Based on the comprehensive functional assessment or review, the interdisciplinary team will:

   a. identify in each such assessment or review each individual's functional disabilities and need for home and community care, including information about the individual's health status, home and community environment, and informal support system; and

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES FOR THE CATEGORICALLY NEEDY

b. based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.

13. The results of the comprehensive functional assessment or review will be used in establishing, reviewing and revising the person's individual community care plan (ICCP).

14. An ICCP will be developed by a qualified community care case manager for each individual who has been determined, on the basis of a comprehensive functional assessment, to be a functionally disabled elderly individual.

15. All services will be furnished in accordance with a written ICCP which:

a. is established, and periodically reviewed and revised, by a qualified community care case manager after a face-to-face interview with the individual or primary care giver;

b. is based upon the most recent comprehensive functional assessment .of the individual;

c. specifies, within the amount, duration and scope of service limitations specified in Appendix C, the home and community care to be provided under the plan. The ICCP will specify the community care services to be provided, their frequency, and the type of provider to furnish each service;

d. indicates the individual's preferences for the types and providers of services and documents the individual's free choice of providers and services to be furnished; and

e. may specify other services required by the individual.

A copy of the ICCP format to be used in implementing this benefit is included in Appendix E.

16. Each individual's ICCP will be established and periodically reviewed and revised by a qualified community care case manager, as provided in Appendix E.

17. A qualified community care case manager is a nonprofit or public agency Y organization which meets the conditions and performs the duties specified in Appendix E.

18. The State will provide the following home and community care services, as defined, described and limited in Appendix C to the groups specified in items 3, 4, 5 and 6 of this Supplement.

a. _____ Homemaker services

b. _____ Home health aide services

c. _____ Chore services

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d. _____ Personal care services

e. _____ Nursing care services provided by, or under the supervision of, a registered nurse

f. _____ Respite care

g. _____ Training for family members in managing the individual

h. _____ Adult day care

i. _____ The following services will be provided to individuals with chronic mental illness:

1. _____ Day treatment/Partial hospitalization

2. _____ Psychosocial rehabilitation services

3. _____ Clinic services (whether or not furnished in a facility)

j. _____ Other home and community-based services (other than room and board) as the Secretary may approve. The following other services will be provided:

1. _____ Habilitation

A. _____ Residential Habilitation

B. _____ Day Habilitation

2. _____ Environmental modifications

3. _____ Transportation

4. _____ Specialized medical equipment and supplies

5. _____ Personal Emergency Response Systems

6. _____ Adult companion services

7. _____ Attendant Care Services

8. _____ Private Duty Nursing Services

9. _____ Extended State plan services (check all that apply):

A. _____ Physician Services

B. _____ Home health care services

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C. _____ Physical therapy services

D. _____ Occupational therapy services

E. _____ Speech, hearing and language services

F. _____ Prescribed drugs

G. _____ Other State plan services (specify): _____

10. _____ Other home and community-based services (specify): ____
_____

19. The State assures that adequate standards for each provider of services exist and will be met. These provider standards are found at Appendix C-2.

20. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are adversely affected by the determinations of the interdisciplinary team, or who are denied the service(s) of their choice, or the provider(s) of their choice, or who disagree with the ICCP which has been established.

21. FFP will not be claimed for the home and community care services specified in item 18 of this Supplement prior to the development of the ICCP. FFP will not be claimed for home and community care services which are not included in the ICCP.

22. The State provides the following assurances to HCFA:

a. Home and community care services will not be furnished to recipients while they are inpatients of a hospital, NF, or ICF/MR.

b. FFP will not be claimed in expenditures for the cost of room board, except when provided as part of respite care furnished in a facility which is (1) approved by the State, and (2) not a private residence. Meals furnished under any community care service (or combination of services) will not constitute a "full nutritional regimen" (3 meals a day).

c. FFP will not be claimed in expenditures for, the cost of room and board furnished to a provider of services.

d. The agency will provide HCFA annually with information on the amount of funds obligated by the State with respect to the provision of home and community care to the functionally disabled elderly in that fiscal year. These reports will begin with information relative to FFY 1990 and will be provided in the manner prescribed by HCFA. The State assures that it will provide data on its maintenance of effort, as required by section 1929(e) of the Social Security Act, in such format and at such times as are specified by HCFA.

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e. The home and community care provided in accordance with this Supplement and Appendices will meet all requirements for individual's rights and quality of care as are published or developed by HCFA.

1. All individuals providing care are competent to provide such care; and

2. Each provider of services under this benefit will meet the requirements applicable to the provision of home and community care as set forth in Appendix C.

3. Each individual receiving home and community care will be accorded the rights specified in Appendix F.

4. Case managers will comply with all standards and procedures set forth in Appendix E.

23. FFP will not be claimed for the home and community care services specified in item 18 of this Supplement in any quarter to the extent that cost of such care in the quarter exceeds 50 percent of the product of:

a. the average number of individuals in the quarter receiving home and community care;

b. the average per diem rate of Medicare payment for extended care services (without regard to coinsurance) furnished in the State during such quarter; and

c. the number of days in such quarter.

24. Community care settings in which home and community care is provided will meet the requirements set forth in section 1929(g) and (h) of the Act, as applicable to the specific setting. The State assures that the requirements of Appendix G will be met for each setting in which home and community care is provided under this section.

25. The State will refuse to provide home and community care in settings which. have been found not to meet the requirements of sections 1929(g) and (h) of the Act.

26. The State will comply with the requirements of section 1929(i), of the Act, regarding survey and certification of community care settings, as set forth in Appendix G.

27. The State will comply with the requirements of section 1929(i) of the Act, regarding the compliance of providers of home and community care and reviews of this compliance, as set forth in Appendix C.

28. The State will provide for an enforcement process for providers of community care, as required by section 1929(j) of the Act. This process is described in Appendix C.

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29. The State assures that payment for home and community care services will be made through rates which are reasonable and adequate to meet the costs of providing care efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

30. Payment will not be made for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under title XIX or title XI of the Social Security Act or for legal expenses in defense of an exclusion or civil money penalty under title XIX or title XI of the Social Security Act if there is no reasonable legal ground for the provider's case.

31. The State will begin provision of services under section 1905(a)(23) of the Social Security Act effective (specify date):

_____

These services will be provided to eligible individuals for a minimum of four calendar quarters, beginning on this date.

32. Services will be provided to eligible recipients for the duration of the period specified in item 31, above, without regard to the amount of Federal *financial participation* available to the State.

33. The State assures that it will monitor the appropriateness and accuracy of the assessments and reviews. Through its monitoring, the State assures the appropriateness and accuracy of the assessments and periodic reviews. The State assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.

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MEDICAID ELIGIBILITY GROUPS SERVED

a. Home and community care services will be made available to individuals age 65 or older, when the individuals have been determined to be functionally disabled as specified in Appendix B.

b. Individuals served under this provision must meet the following Medicaid eligibility criteria (check all that apply):

1. _____ Age 65 or older who have been determined to be functionally disabled (as determined under the SSI program) as specified in Appendix B.

A. _____ The agency uses the same methodologies for treatment of income and resources as used in the SSI program (or the optional State supplement program which meets the requirements of 42 CFR 435.230, as appropriate). Individuals must be receiving SSI/SSP benefits to be eligible under this provision.

B. _____ The agency uses methodologies for treatment of income and resources that differ from those of the SSI program. These differences result from restrictions applied under section 1902(f) of the Act. The methodologies are described in Supplement 5 to Attachment 2.6-A. Individuals must be eligible for Medicaid under the State's plan to be eligible under this provision.

2. _____ Medically needy, age 65 or older who have been determined to be functionally disabled as specified in Appendix B. In determining the individual's eligibility, the State may, at its option, provide for the determination of the individual's anticipated medical expenses (to be deducted from income). (Check one):

A. _____ The State does not consider anticipated medical expenses.

B. _____ The State considers anticipated medical expenses over a period of _____ months (not to exceed 6 months).

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INDIVIDUALS PREVIOUSLY COVERED UNDER A WAIVER

a. _____ The State used a health insuring organization before January 1, 1986, and had in effect a waiver under §1115 of the Act, which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. In accordance with S1929(b)(2)(B) of the Act, the following individuals will be eligible to receive home and community care services. (Check all that apply):

1. _____ Age 65 or older.

2. _____ Disabled, receiving SSI.

These individuals meet the resource requirement and income standards that apply in the State to individuals described in 51902(a)(10)(A)(ii)(V) of the Act.

b. _____ In accordance with S1929(b)(2)(A) the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. This waiver was terminated during the period in which the State furnished home and community care to functionally disabled elderly individuals under its state plan. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

c. _____ In accordance with S1929(b)(2)(A) the Act, individuals age 65 or older, who were served under a waiver granted pursuant to section 1915(d)of the Act on the date on which that waiver was terminated. This waiver was terminated during the period in which the State furnished home and community care to functionally disabled elderly individuals under its State plan. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

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FUNCTIONAL DISABILITY

Home and community care services, as defined in this Supplement, are provided to the following classifications of individuals who have been found on the basis of an assessment to be functionally disabled. Services will be limited to individuals who meet the following targeting criteria.

Check all that apply:

a. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with at least two of the following activities of daily living: toileting, transferring, eating.

b. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with each of the following activities of daily living: toileting, transferring, eating.

c. _____ Services are provided to individuals who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, at least 2 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

d. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, (check one):

1. _____ at least 3 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

2. _____ at least 4 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

3. _____ all of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

e. _____ Services are provided to individuals who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are sufficiently cognitively impaired so as to require substantial supervision from another individual because they engage in inappropriate behaviors that pose serious health or safety hazards to themselves or others.

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AGE

Check all that apply:

a. _____ Services are provided to individuals age 65 and older.

b. _____ Services are provided to individuals who have reached at least the following age, greater than 65 (specify): _____

c. _____ Services are provided to individuals who meet the criteria set forth in item 3.b. of Supplement 2, as set forth in Appendix B-3, who were 65 years of age or older on the date of the waiver's discontinuance.

d. _____ Services are provided to individuals who meet the criteria set forth in item 3.c. of Supplement 2, as set forth in Appendix B-3, who were served under the waiver on the date of its discontinuance.

e. _____ Services are provided to individuals who meet the criteria in item 3.d. of Supplement 2, who fall within the following age categories (check all that apply):

1. _____ Age 65 and older

2. _____ Age greater than 65. Services are limited to those who have attained at least the age of (specify): _____

3. _____ Age less than 65. Services will be provided to those in the following age category (specify): _____

4. _____ The State will impose no age limit.

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INDIVIDUALS PREVIOUSLY SERVED UNDER WAIVER AUTHORITY

a. _____ In accordance with 1929(b)(2)(A) of the Act, the State will discontinue the following home and community-based services waiver(s), approved under the authority of $1915(c) or §1915(d) of the Act. (Specify the waiver numbers):

Waiver Number	Last date of waiver operation
_____	_____
_____	_____
_____	_____
_____	_____

b. For each waiver specified in Appendix B-3-a, above, the State will furnish at least 30 days notice of service discontinuance to those individuals under 65 years of age, and to those individuals age 65 or older who do not meet the test of functional disability specified in Appendix B-1 (except those individuals who will continue to receive home and community-based services under a different waiver program).

c. Individuals age 65 years of age or older, who were eligible for benefits under a waiver specified in Appendix B-3-a on the last date of waiver operation, who would, but for income or resources, be eligible for home and community care under the State plan, shall be deemed functionally disabled elderly individuals for so long as they would have remained eligible for services under the waiver.

d. The financial eligibility standards which were in effect on the last date of waiver operation are attached to this Appendix.

e. The following are the schedules, in effect on the last date of waiver operation, under which individuals served under a waiver identified in Appendix B-3-a were reevaluated for financial eligibility (specify):

Waiver Number	Reevaluation schedule
_____	_____
_____	_____
_____	_____
_____	_____

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DEFINITION OF SERVICES

The State requests that the following services, as described and defined herein, be provided as home and community care services to functionally disabled elderly individuals under this program:

a. _____ Homemaker Services. (Check one.)

_____ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities. This service does not include medical care of the client. Hands-on care is limited to such activities as assistance with dressing, uncomplicated feeding, and pushing a wheelchair from one room to another. Direct care furnished to the client is incidental to care of the home. These standards are included in Appendix C-2.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify):

b. _____ Home Health Aide Services. (Check one.)

_____ Services defined in 42 CFR 440.70 with the exception that limitations on the amount, duration and scope of such services shall instead be governed by the limitations imposed below.

_____ Other Service Definition: _____

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DEFINITION OF SERVICES (con't)

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify):

c. _____ Chore Services. (Check one.)

_____ Services identified in the ICCP which are needed to maintain the individual's home in a clean, sanitary and safe environment. For purposes of this section, the term "home" means the abode of the individual, whether owned or rented by the client, and does not include the residence of a paid caregiver with whom the client resides (such as a foster care provider), or a small or large community care facility.

Covered elements of this service include heavy household chores such as washing floors, windows and walls, removal of trash, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access inside the home for the recipient, and shoveling snow to provide access and egress.

Chore services will be provided only in cases where neither the client, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following l imitations on the provision of this service (specify):_____

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DEFINITION OF SERVICES (con't)

Provider qualifications are specified in Appendix C-2.

d. _____ Personal Care Services. (Check one.)

_____ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service includes meal preparation, when required by the individual community care plan (ICCP), but does not include the cost of the meals. When specified in the ICCP, this service also includes such housekeeping chores as bedmaking, cleaning, shopping, or escort services which are appropriate to maintain the health and welfare of the recipient. Providers of personal care services must meet State standards for this service. These standards are included in Appendix C-2.

_____ Other Service Definition:

_____

_____

1. Services provided by family members. Check one:

_____ Payment will not be made for personal care services furnished by a member of the recipient's family or by a person who is legally or financially responsible for that recipient.

_____ Personal care providers may be members of the recap recipient's family. Payment will not be made for services furnished to a minor by the recipient's parent (or stepparent), or to a recipient by the recipient's spouse. Payment will not be made for services furnished to a recipient by a person who is legally or financially responsible for that recipient.

Check one:

_____ Family members who provide personal care services must meet the same standards as other personal care providers who are unrelated to the recipient. These standards are found in Appendix C-2.

_____ Standards for family members who provide personal care services differ from those for other providers of this service. The standards for personal care services provided by family members are found in Appendix C-2.

2. Personal care providers will be supervised by:

_____ a registered nurse, licensed to practice nursing in the State

_____ case managers

_____ other (specify): _____

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DEFINITION OF SERVICES (con't)

3. Minimum frequency or intensity of supervision:

_____ as indicated in the client's ICCP

_____ other (specify): _____

4. Personal care services are limited to those furnished in a recipient's home.

_____ Yes _____ No

5. Limitations (check one):

_____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

_____ The State will impose the following limitations on the provision of this service (specify): _____

e. _____ Nursing Care Services Provided By or Under The Supervision of a Registered Nurse.

_____ Nursing services listed in the ICCP which are within the scope of State law, and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Standards for the provision of this service are included in Appendix C-2.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

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DEFINITION OF SERVICES (con't)

f. _____ Respite care. (Check one.)

_____ Services given to individuals unable to care for themselves; provided on a short-term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

_____ Other Service Definition: _____

1. Respite care will be provided in the following location(s):

_____ Recipient's home or place of residence

_____ Foster home

_____ Facility approved by the State which is not a private residence

2. The State will apply the following limits to respite care provided in a facility.

_____ Hours per recipient per year

_____ Days per recipient per year

_____ Respite care will be provided in accordance with the ICCP. There are no set limits on the amount of facility-based respite care which may be utilized by a recipient.

_____ Not applicable. The State does not provide facility-based respite care.

3. Respite care will be provided in the following type(s) of facilities.

_____ Hospital

_____ NF

_____ ICF/MR

_____ Group home

_____ Licensed respite care facility

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DEFINITION OF SERVICES (con't)

_____ Other (specify): _____

_____ Not applicable. The State does not provide facility-based respite care.

4. The State will apply the following limits to respite care provided in a community setting which is not a facility (including respite care provided in the recipient's home).

_____ Hours per recipient per year

_____ Days per recipient per year

_____ Respite care will be provided in accordance with the ICCP. There are no set limits on the amount of community-based respite care which may be utilized by a recipient.

_____ Not applicable. The State does not provide respite care outside a facility-based setting.

Qualifications of the providers of respite care services are included in Appendix C-2. Applicable Keys amendment (section 1616(e) of the Social Security Act) standards are cited in Appendix F-2.

g. _____ Training for Family Members in Managing the Individual. (Check one.)

_____ Training and counseling services for the families of functionally disabled elderly individuals. For purposes of this service, "family" is defined as the persons who live with or provide care to a disabled individual, and may include a spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the functionally disabled individual. Training includes instruction about treatment regimens and use of equipment specified in the ICCP and shall include updates as may be necessary to safely maintain the individual at home. This service is provided for the purpose of increasing the ability of a primary caregiver or a member of the recipient's family to maintain and care for the individual at home. All training for family members must be included in the client's ICCP.

_____ Other Service Definition: _____

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DEFINITION OF SERVICES (con't)

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify):

_____
_____
_____
_____
_____

Provider qualifications are specified in Appendix C-2.

h. _____ Adult Day Care. (Check one.)

_____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the client. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

_____ Other Service Definition: _____
_____
_____
_____

Check all that apply:

1. _____ Physical therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of physical therapy will be included in the rate paid to providers of adult day care services.

2. _____ Occupational therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of occupational therapy will be included in the rate paid to providers of adult day care services.

3. _____ Speech therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of speech therapy will be included in the rate paid to providers of adult day care services.

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4. _____ Nursing care furnished by or under the supervision of a registered nurse, and indicated in the individual's ICCP, will be provided by the facility as a component part of this service.

5. _____ Transportation between the recipient's place of residence and the adult day care center will be provided as a component part of this service. The cost of this transportation is included in the rate paid to providers of adult day care services.

6. _____ Other therapeutic activities which will be provided by the facility as component parts of this service. (Specify): ____
_____
_____
_____
_____

Limitations. Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____
_____
_____
_____
_____

Qualifications of the providers of this service are found in Appendix C-2.

i. _____ Services for individuals with chronic mental illness, consisting of (Check all that apply):

1. _____ Day Treatment or other Partial Hospitalization Services. (Check one.)

_____ Services that are necessary for the diagnosis or active treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

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DEFINITION OF SERVICES (con't)

b. occupational therapy, requiring the skills of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients,

d. drugs and biologicals furnished for therapeutic purposes,

e. individual activity therapies that are not primarily recreational or diversionary,

f. family counseling (the primary purpose of which is treatment of the individual's condition),

g. patient training and education (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

h. diagnostic services.

Meals and transportation are excluded from reimbursement under this benefit. The purpose of this benefit is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

_____ Other Service Definition: _____

Limitations. Check one:

a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

b. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

2. _____ Psychosocial Rehabilitation Services. (Check one.)

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DEFINITION OF SERVICES (con't)

_____ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- o Restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- o Social skills training in appropriate use of community services;
- o Development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- o Telephone monitoring and counseling services.

The following services are specifically excluded from Medicaid payment:

Vocational services,
Prevocational services,
Supported employment services,
Educational services, and
Room and board.

_____ Other Service Definition: _____
_____
_____

Psychosocial rehabilitation services are furnished in the following locations (check all that apply):

a. _____ Individual's home or place of residence

b. _____ Facility in which the individual does not reside

c. _____ Other (Specify): _____
_____
_____
_____

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DEFINITION OF SERVICES (con't)

Limitations. Check one:

a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

b. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

3. _____ Clinic services (Whether or Not Furnished *in* a Facility) are services defined in 42 CFR 440.90.

Check one:

a. _____ This benefit is limited to those services furnished on the premises of a clinic.

b. _____ Clinic service may be furnished outside the clinic facility. Services may be furnished in the following locations (specify): _____

Check one:

a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

b. _____ The State will impose the following limitations on the provision of this service (specify):

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DEFINITION OF SERVICES (con't)

Qualifications of the providers of this service are found in Appendix C-2.

j. _____ Habilitation. (Check one.)

_____ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully at home or in the community. This service includes:

1._____ Residential habilitation: assistance with acquisition, retention or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a home or community setting. Payments for residential habilitation are not made for room and board, or the costs of facility maintenance, upkeep, and improvement. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the recipient's immediate family. Payments will not be made for routine care and supervision, or for activities or supervision for which a payment is available from a source other than Medicaid. The methodology by which payments are calculated and made is described in Attachment 4.19-B.

2._____ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the recipient resides. Services shall normally be furnished 4 or more hours per day, on a regularly scheduled basis, for 1 or more days per week, unless provided as an adjunct to other day activities included in the recipient's ICCP. Day habilitation services shall focus on enabling the individual to attain or retain his or her maximum functional level.

_____ Other Service Definition: _____
_____
_____
_____

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DEFINITION OF SERVICES (con't)

Check all that apply:

A. _____ Physical therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of physical therapy will be included in the rate paid to providers of habilitation services.

B. _____ Occupational therapy indicated in the individual's CCP will be provided by to facility as a component part of this service. The cost of occupational therapy will be included in the rate paid to providers of habilitation services.

C. _____ Speech therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of speech therapy will be included in the rate paid to providers of habilitation services.

D. _____ Nursing care furnished by or under the supervision of a registered nurse, and indicated in the individual's ICCP, will be provided by the facility as a component part of this service.

E. _____ Transportation between the recipient's place of residence and the habilitation center will be provided as a component part of this service. The cost of this transportation is included in the rate paid to providers of habilitation services.

F. _____ Other therapeutic activities which will be provided by the facility as component parts of this service. (Specify): _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on to amount or duration of services furnished.

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DEFINITION OF SERVICES (con't)

2. _____ The State will impose the following limitations on the provision of this service (specify):
_____
_____
_____

Payment will not be made for the following:

Vocational Services;
Prevocational services;
Educational services; or
Supported employment services.

Qualifications of the providers of this service are specified in Appendix C-2.

k. _____ Environmental Modifications. (Check one.)

_____ Those physical adaptations to the home, required by the individual's ICCP, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home.

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies the need for which is identified in the client's ICCP.

Adaptations or improvements to the home which are of general utility, or which are not of direct medical or remedial benefit to the client, such as carpeting, roof repair, central air conditioning, etc., are specifically excluded from this benefit. All services, shall be provided in accordance with applicable State or local building codes.

_____ Other Service Definition: _____
_____
_____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

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DEFINITION OF SERVICES (con't)

2. _____ The State will impose the following limitations on the provision of this service (specify):
_____
_____
_____

l. _____ Transportation. (Check one.)

_____ Service offered in order to enable individuals receiving home and community care under this section to gain access to services identified in the ICCP. Transportation services under this section shall be offered in accordance with the recipient's ICCP, and shall be used only when the service is not available without charge from family members, neighbors, friends, or community agencies, and when the appropriate type of transportation is not otherwise provided under the State plan. In no case will family members be reimbursed for the provision of transportation services under this section.

_____ Other Service Definition: _____
_____
_____
_____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____
_____
_____
_____

Provider qualifications are specified in Appendix C-2.

m. _____ Specialized Medical Equipment and Supplies. (Check one.)

_____ Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the ICCP, which enable clients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which

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DEFINITION OF SERVICES (con't)

they live. This service also includes items necessary for life support, service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and supplies not otherwise available under the State plan. Items which are not of direct medical or remedial benefit to the recipient are excluded from this service. All specialized medical equipment and supplies provided under this benefit shall meet applicable standards of manufacture, design and installation.

_____ Other Service Definition: _____
_____
_____
_____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____
_____
_____
_____

n. _____ Personal Emergency Response Systems (PERS). (Check one.)

_____ PERS is an electronic device which enables certain high-risk clients to secure help in the event of an emergency. The client may also wear a portable "help" button to allow for mobility. The system is connected to the client's phone and programmed to signal a response center once the "help" button is activated. The response center is staffed by individuals with the qualifications specified in Appendix C-2.

_____ Other Service Definition: _____
_____
_____
_____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

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DEFINITION OF SERVICES (con't)

2. _____ The State will impose the following limitations on the provision of this service (specify): _____
_____
_____
_____

o. _____ Adult Companion Services. (Check one.)

_____ Non-medical care, supervision and socialization provided to a functionally disabled adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on medical care. Companion services may include non-medical care of the client, such as assistance with bathing, dressing and uncomplicated feeding. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the client. This service is provided in accordance with a therapeutic goal in the ICCP, and is not merely diversionary in nature.

_____ Other Service Definition: _____
_____
_____
_____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____
_____
_____
_____

Provider qualifications are specified in Appendix C-2.

3. Services provided by family members. (Check one.)

A. _____ Payment will not be made for adult companion services furnished by a member of the recipient's family or by a person who is legally or financially responsible for that recipient.

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DEFINITION OF SERVICES (con't)

B. _____ Adult companion service providers may be members of the recipient's family. Payment will not be made for services furnished to a minor by the recipient's parent (or stepparent), or to a recipient by the recipient's spouse. Payment will not be made for services furnished to a recipient by a person who is legally or financially responsible for that recipient.

Check one:

1. _____ Family members who provide adult companion services must meet the same standards as other adult companion providers who re unrelated to the recipient. These standards are found in Appendix C-2.

2. _____ Standards for family members who provide adult companion services differ from those for other providers of this service. The standards for adult companion services provided by family members are found in Appendix C-2.

p. _____ Attendant Care. (Check one.)

_____ Hands-on care, of both a medical and non-medical supportive nature, specific to the needs of a medically stable, physically handicapped individual. This service may include skilled medical care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of the client-based care may also be furnished as part of this activity.

_____ Other Service Definition: _____
_____
_____
_____

Check all that apply:

1. _____ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the ICCP.

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DEFINITION OF SERVICES (con't)

2. _____ Supervision may be furnished directly by the client, when the client has been trained to perform this function, and when the safety and efficacy of client-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on observation of the client and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained with the client's ICCP.

3. _____ Other supervisory arrangements: _____
_____
_____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____
_____
_____
_____
_____

Provider qualifications are specified in Appendix C-2.

q. _____ Private Duty Nursing. (Check one.)

_____ Private duty nursing services consist of individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within their scope of practice under State law.

_____ Other Service Definition: _____
_____
_____
_____

Check one:

1. _____ Private duty nursing services are limited to services provided in the individual's home or place of residence.

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DEFINITION OF SERVICES (con't)

2. _____ Private duty nursing services are not limited to services provided in the individual's home or place of residence.

Check one:

A. ___X___ Services may also be provided in the following locations (Specify): Only in the individual's home or in a licensed adult family home that has a contract (in accordance with state rules for these homes) with the state.

B. _____ The State will not place limits on the site of private duty nursing services.

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. ___X___ The State will impose the following limitations on the provision of this service (specify):

a. The client must require at least 4 continuous hours of skilled nursing care on a daily basis; and

b. Must require at least one of the following on a daily basis:
(1) A mechanical ventilator;
(2) Tracheostomy tube care/suctioning;
(3) Intravenous/parenteral administration of medications; or
(4) Intravenous administration of nutritional substances.

r. _____ Extended State Plan Services. The following services are available under the State plan, but with limitations. Under this benefit, these services will be provided in excess of the limitations otherwise specified in the plan. Provider standards will remain unchanged from those otherwise indicated in the State plan. When these services are provided as home and community care, the limitations on each service will be as specified in this section.

1. _____ Physician services.

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____
_____

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DEFINITION OF SERVICES (con't)

2. _____ Home Health Care Services

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____
_____
_____

3. _____ Physical Therapy Services

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____
_____
_____

4. _____ Occupational Therapy Services

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____
_____
_____

5. _____ Speech, Hearing and Language Services

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

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DEFINITION OF SERVICES (con't)

B. _____ The State will impose the following limitations on the provision of this service (specify): _____
_____
_____

6. _____ Prescribed Drugs

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____
_____
_____

s. _____ Other services (specify): _____
_____
_____
_____
_____

Provider standards for each “other” services identified are found in Appendix C-2.

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PROVIDER QUALIFICATIONS

a. The following are the minimum qualifications for the provision of each home and community care service under the plan.

LICENSURE AND CERTIFICATION CHART

Cite relevant portions of State licensure and certification rules as they apply to each service to be provided.

SERVICE	PROVIDER TYPE	LICENSURE	CERTIFICATION
HOMEMAKER			
HOME HEALTH AIDE			
CHORE SERVICES			
PERSONAL CARE			
NURSING CARE			
RESPITE CARE			
IN HOME			
FACILITY BASED			
FAMILY TRAINING			
ADULT DAY CARE			
DAY TREATMENT/ PARTIAL HOSPITALIZATION			
PSYCHOSOCIAL REHABILITATION			
CLINIC SERVICES			

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PROVIDER QUALIFICATIONS (con't)

SERVICE	PROVIDER TYPE	LICENSURE	CERTIFICATION
HABILITATION			
RESIDENTIAL			
DAY			
ENVIRONMENTAL MODIFICATIONS			
TRANSPORTATION			
MEDICAL EQUIPMENT AND SUPPLIES			
PERSONAL EMERGENCY RESPONSE SYSTEMS			
ADULT COMPANION			
ATTENDANT CARE			
PVT DUTY NURSING			

Identify any licensure and certification standards applicable to the providers of "other" services defined in Appendix C-1 on a separate sheet of paper. Attach the paper to this Appendix.

Identify any additional standards applicable to each service on a separate sheet of paper. Attach the paper to this Appendix.

b. ASSURANCE THAT REQUIREMENTS ARE MET

1. The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under this section.
2. The State will require each provider furnishing services under this section to furnish proof that all applicable requirements for service provision, specified in this Appendix, are met prior to the provision of services for which FFP is claimed.
3. The State assures that it will review each provider at least once a year, to ensure that provider requirements continue to be met.

c. PROVIDER REQUIREMENTS APPLICABLE TO ALL SERVICES

In addition to standards of licensure and certification, each individual furnishing services under this section must demonstrate the following to the satisfaction of the State:

1. Familiarity with the needs of elderly individuals. The degree of familiarity must be commensurate with the type of service to be provided.

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State WASHINGTON

PROVIDER QUALIFICATIONS (con't)

2. If the provider is to furnish services to individuals with Alzheimer's Disease or to recipients with other mental impairments, familiarity with the course and management of this disease, commensurate with the type of service to be provided.

3. The provider must furnish proof of sufficient ability to communicate with the client or primary caregiver. To be considered sufficient, this ability must be commensurate with the type of service to be provided.

4. Each provider must have received training, appropriate to the demands of the service to be provided, in proper response to emergency situations. This training must include instruction in how to contact the client's case manager.

5. Each provider must be qualified by education, training, experience and/or examination in the skills necessary for the performance of the service.

6. Providers may meet these standards by the following methods:

   A. Education, including formal degree requirements specified in the provider qualifications for the service to be furnished.

   B. Specific course(s), identified in the provider qualifications for the service to be furnished.

   C. Documentation that the provider has completed the equivalent of the courses) identified in item c.6-B, above.

   D. Training provided by the Medicaid agency or its designee.

      The Medicaid agency or its designee will also make this training available to unpaid providers of service.

      _____ Yes _____ No

   E. Appropriate experience (specified in the provider qualifications for the applicable service), which may substitute for the education and training requirements otherwise applicable.

   F. The provider may demonstrate competence through satisfactory performance of the duties attendant upon the specified service. With regard to particular providers, and particular services, the State may also choose to require satisfactory completion of a written or oral test. Test requirements are included in the provider requirements applicable to the specific service.

   Specific standards of education, training, experience, and/or demonstration of competence applicable to each service provided are attached to this Appendix.

d. PROVIDER REQUIREMENTS SPECIFIC TO EACH APPLICABLE TO ALL SERVICES

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PROVIDER QUALIFICATIONS (con't)

SERVICE	MINIMUM QUALIFICATIONS OF PROVIDERS
HOMEMAKER	
HOME HEALTH AIDE	Providers of Home Health Aide services meet the qualifications set forth at 42 CFR Part 484 for the provision of this service under the Medicare program. Additional qualifications:
CHORE SERVICES	
PERSONAL CARE	
NURSING CARE	
RESPITE CARE IN HOME	
FACILITY BASED	
FAMILY TRAINING	
ADULT DAY CARE	
DAY TREATMENT/PARTIAL HOSPITALIZATION	Day treatment/partial hospitalization services are furnished by a hospital to its outpatients, or by a community mental health center. They are furnished by a distinct and organized ambulatory treatment center which offers care less than 24 hours a day.
PSYCHOSOCIAL REHABILITATION	
CLINIC SERVICES	
HABILITATION GENERAL STANDARDS	
RESIDENTIAL HABILITATION	
DAY HABILITATION	

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PROVIDER QUALIFICATIONS (con't)

SERVICE	MINIMUM QUALIFICATIONS OF PROVIDERS
ENVIRONMENTAL MODIFICATIONS	
TRANSPORTATION	
MEDICAL EQUIPMENT AND SUPPLIES	
PERSONAL EMERGENCY RESPONSE SYSTEMS	
ADULT COMPANION	
ATTENDANT CARE	
PVT DUTY NURSING	

Identify the provider requirements applicable to the providers of each "other" service specified in Appendix C-1 on a separate sheet of paper. Attach the paper to this Appendix.

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State WASHINGTON

ASSESSMENT

a. The State will provide for a comprehensive functional assessment for a financially eligible individual who meet the targeting requirements set forth in items 3 and 4 of Supplement 2.

b. This assessment will be provided at the request of the individual, or another person acting on the individual's behalf.

c. The individual will not be charged a fee for this assessment.

d. Attached to this Appendix is an explanation of the procedures by which the state will ensure the performance of the assessment.

e. The assessment will be reviewed and revised not less often than (check one):

1. _____ Every 12 months

2. _____ Every 6 months

3. _____ Other period not to exceed 12 months (Specify): _____
_____

f. Check one:

1. _____ The State will use an assessment instrument specified by HCFA.

2. _____ The State will use an assessment instrument of its own specification. A copy of this instrument is attached to this Appendix. The State certifies that this instrument will measure functional disability as specified in section 1929(b) and (c) of the Act. The State requests that HCFA approve the use of this instrument, and certifies that at such time as HCFA may publish a minimum data set (consistent with section 1929(c)(2) of the Act), the assessment instrument will be revised, as determined necessary by HCFA, to conform to the core elements, common definitions, and uniform guidelines which are contained in the minimum data set.

g. In conducting the assessment (or the periodic review of the assessment), the interdisciplinary team must:

1. Identify in each such assessment or review each individual's functional disabilities; and

2. Identify in each such assessment or review each individual's need for home and community care. This identification shall include:

A. Information about the individual's health status;

B. Information about the individual's home and community environment; and

C. Information about the individual's informal support system.

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State WASHINGTON

ASSESSMENT (con't)

3. Determine whether the individual is, or continues to be, functionally disabled. This determination will be made on the basis of the assessment or review.

h. The interdisciplinary team conducting the assessment shall furnish the results to the Medicaid agency and to the qualified community care case manager designated by the Medicaid agency (as specified in Appendix F,) to establish, review and revise the individual's ICCP.

i. The Medicaid agency will monitor the appropriateness and accuracy of the assessments and periodic reviews on an ongoing basis, and whenever it is informed by a qualified community care case manager that inaccuracies appear to exist in the assessment of an individual. All problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.

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State WASHINGTON

INTERDISCIPLINARY TEAM

a. Initial assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. _____ The interdisciplinary teams will be employed directly by the Medicaid agency.

2. _____ The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.

3. _____ The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.

4. _____ The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation, or relationship with, an entity that provides community care or nursing facility services.

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting comprehensive functional assessments.

When assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the assessments without the prior written approval of the Medicaid agency.

b. Periodic reviews of assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. _____ The interdisciplinary teams will be employed directly by the Medicaid agency.

2. _____ The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.

3. _____ The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.

4. _____ The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation, or relationship with, an entity that provides community care or nursing facility services.

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INTERDISCIPLINARY TEAM (con't)

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting periodic reviews of the individuals' comprehensive functional assessments.

When periodic reviews of assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the periodic reviews without the prior written approval of the Medicaid agency.

c. The interdisciplinary teams conducting initial assessments shall consist, at a minimum, of (check all that apply, but at least 2):

1. _____ Registered nurse, licensed to practice in the State
2. _____ Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. _____ Physician (M.D. or D.O.), licensed to practice in the State
4. _____ Social Worker (qualifications attached to this Appendix)
5. _____ Case manager
6. _____ Other (specify): _____
_____

d. The interdisciplinary teams conducting periodic reviews of assessments shall consist, at a minimum, of (check all that apply, but at least 2):

1. _____ Registered nurse, licensed to practice in the State
2. _____ Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. _____ Physician (M.D. or D.O.), licensed to practice in the State
4. _____ Social Worker (qualifications attached to this Appendix)
5. _____ Case manager
6. _____ Other (specify): _____
_____

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State WASHINGTON

INDIVIDUAL COMMUNITY CARE PLAN (ICCP)

a. A written individual community care plan (ICCP) will be developed for each individual who has been determined, on the basis of a comprehensive functional assessment performed in accordance with Appendix D, to be a functionally disabled elderly individual, according to the criteria set forth in Appendices A and B.

b. The ICCP will be established, and periodically reviewed and revised, by a Qualified Community Care Case Manager after a face-to-face interview with the individual or primary caregiver.

c. The ICCP will be based on the most recent comprehensive functional assessment of the individual conduced according to Appendix D.

d. The ICCP will specify, within the amount, duration and scope of service limitations set forth in Appendix C, the home and community care to be provided to such individual under the plan.

e. The ICCP will indicate the individual's preferences for the types and providers of services.

f. The ICCP will specify home and community care and other services required by such individual. (Check one):

1. _____ Yes 2. _____ No

g. The ICCP will designate the specific providers (who meet the qualifications specified in Appendix C-2) which will provide the home and community care. (Check one):

1. _____ Yes 2. _____ No

h. Neither the ICCP, nor the State, shall restrict the specific persons or individuals (who meet the requirements of Appendix C-2) who will provide the home and community care specified in the ICCP.

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State WASHINGTON

QUALIFIED COMMUNITY CARE CASE MANAGERS

a. "Qualified Community Care Case Manager" will meet each of the following qualifications for the provision of community care case management.

1. Be a nonprofit or public agency or organization;

2. Have experience or have been trained in:

A. Establishing and periodically reviewing and revising ICCPs; and

B. The provision of case management services to the elderly.

The minimum standards of experience and training which will be employed by the State are attached to this Appendix;

3. Have procedures for assuring the quality of case management services. These procedures will include a peer review process.

4. The State will assure that community care case managers are competent to perform case management functions, by requiring the following educational or professional qualifications be met. (Check all that apply):

A. _____ Registered nurse, licensed to practice in the State

B. _____ Physician (M.D. or D.O.), licensed to practice in the State

C. _____ Social Worker (qualifications attached to this Appendix)

D. _____ Other (specify): _____
_____
_____

b. When community care case management is provided by a nonprofit, nonpublic agency, the agency providing the community case management will not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides home and community care or nursing facility services and will not furnish home and community care or nursing facility services itself. (Check one):

1. _____ Yes

2. _____ Not applicable. The State will not use nonprofit, nonpublic agencies to provide community care case management.

c. The State will employ procedures to assure that individuals whose home ad community care is managed by qualified community care case managers are not at risk of financial exploitation due to such managers. An explanation of these procedures is attached to this Appendix

.

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State WASHINGTON

QUALIFIED COMMUNITY CARE CASE MANAGERS (cont)

d. The State requests that the requirements of item E-2-b be waived in the case of a nonprofit agency located in a rural area. The State's definition of "rural area" is attached to this Appendix. (Check one):

1. _____ Yes 2. _____ No

3. _____ Not applicable. The State will not use nonprofit nonpublic agencies to provide community care case management.

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State WASHINGTON

COMMUNITY CARE CASE MANAGEMENT FUNCTIONS

a. A qualified community care case manager is responsible for:

1. Assuring that home and community care covered under the State plan and specified in the ICCP is being provided;

2. Visiting each individual's home or community care setting where care is being provided not less often than once every 90 days;

3. Informing the elderly individual or primary caregiver how to contact the case manager if service providers fail to properly provide services or other similar problems occur. This information will be provided verbally and in writing.

4. Completes the ICCP in a timely manner; and

5. Reviews and discusses new and revised ICCPs with elderly individuals or primary caregivers.

b. Whenever a qualified community care case manager has reason to believe that an individual's assessment or periodic review (conducted under Appendix D) appears to contain inaccuracies, the community care case manager will bring these apparent discrepancies to the attention of the agency which has performed the assessment or review. If the assessors and the community care case manager are unable to resolve the apparent conflict, the case manager shall report the situation to the component of the Medicaid agency which is responsible for monitoring the program.

1. _____ Yes 2. _____ No

c. Whenever a qualified community care case manager is informed by an elderly individual or primary caregiver that provider(s) have failed to provide services, or that other similar problems have occurred, the community care case manager shall take whatever steps are necessary to verify or disprove the complaint. If a problem is confirmed by this monitoring, the community care case manager shall address the problem in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted. This may include reporting the situation to the component of the Medicaid agency which is responsible for monitoring the program.

1. _____ Yes 2. _____ No

d. Whenever a qualified community care case manager is informed by a provider of service (whether paid or unpaid) that there has been a change in the individual's condition, or that a problem may have arisen which is not currently being addressed, the community care case manager shall take whatever steps are necessary to verify or disprove the information. If a problem is confirmed by this monitoring, the community care case manager shall address it in an appropriate and timely manner, consistent with the nature and severity of the situation.

1. _____ Yes 2. _____ No

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

COMMUNITY CARE CASE MANAGEMENT FUNCTIONS (con't)

e. Community care case managers shall verify the qualifications of each individual or agency providing home and community care services prior to the initiation of services, and at such intervals as are specified in Appendix C, thereafter. (Check one):

1. _____ Yes 2. _____ No

f. Where the provision of services in an individual's ICCP is not governed by State licensure or certification requirements, the community care case manager shall verify the qualifications of the individual or entity furnishing the services, and as necessary, provide or arrange for the training specified in Appendix C-2. (Check one):

1. _____ Yes 2. _____ No

3. _____ Not applicable. All services are governed by State licensure or certification requirements.

g. Community care case managers shall inform each elderly individual for whom an ICCP is established of the person's right to a fair hearing should the individual disagree with the contents of the ICCP.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

RIGHTS SPECIFIED IN THE STATUTE

The State assures that home and community care provided under the State plan will meet the following requirements:

a. Individuals providing care are competent to provide such care. The State will maintain documentation to show that each provider of care meets or exceeds the applicable minimum qualifications specified in Appendix C-2.

b. Individuals receiving home and community care shall be assured the following rights:

1. The right to be fully informed in advance, orally and in writing, of the following:

a. the care to be provided,

b. any changes in the care to be provided; and

c. except with respect to an individual determined incompetent, the right to participate in planning care or changes in care.

2. The right to voice grievances with respect to services that are for fail to be) furnished without discrimination or reprisal for voicing grievances, and to be told how to complain to State and local authorities. A description of the procedures which the State will utilize to ensure this right is attached to this Appendix.

3. The right to confidentiality of personal and clinical records.

4. The right to privacy and to have one's property treated with respect.

5. The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

6. The right to education or training for oneself and for members of one’s family or household on the management of care.

7. The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in the individual's ICCP.

8. The right to be fully informed orally and in writing of the individual's rights.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

ADDITIONAL RIGHTS

The State assures that home and community care provided under the State plan will meet the following additional requirements:

a. The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community care services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities. Copies of these standards are maintained at the Medicaid agency.

b. In the case of an individual who has been adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the individual are exercised by the person appointed under State law to act on the individual's behalf.

c. In the case of an individual who resides in his or her own home, or in the home of a relative, when the individual has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the individual's rights to the extent provided by State law. In addition, all rights to be informed of the care to be provided, and to have input into the development of the ICCP specified in Appendix F-1-b shall be extended to the principal caregiver.

d. In the case of an individual who resides in a community care setting, and who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the individual's rights to the extent provided by State law.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

GUIDELINES FOR PROVIDER COMPENSATION

a. The following advisory guidelines are provided for such minimum compensation for individuals providing home and community care. These guidelines will be used to assure the availability and continuity of competent individuals to provide such care for functionally disabled individuals who have functional disabilities of varying levels of severity.

1. For services which are the same as, or similar (in content, complexity and provider qualifications) to those provided under the approved Medicaid State plan, the State will compensate the providers on the same basis as that which is approved as part of the plan.

A. _____ Yes B. _____ No

2. For services which are the same as, or similar (in content, complexity and provider qualifications) to those provided under another program funded and operated by the State, the State will compensate the providers on a basis which is equivalent to that used by the other publicly funded program.

A. _____ Yes B. _____ No

3. For services which are dissimilar to those provided under the plan or another program funded and operated by the State, the State will develop methods of compensation which are sufficient to enlist an adequate number of providers, taking into account the number of individuals receiving the service and their geographic location.

A. _____ Yes B. _____ No

b. The State assures that it will comply with these guidelines.

1. _____ Yes 2. _____ No

c. The methods by which the State will reimburse providers are described in attachment 4.19-B.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

COMMUNITY CARE SETTINGS-GENERAL

a. Definitions.

1. Small residential community care setting. A small residential community care setting is defined as a facility in which between 3 and 8 unrelated adults reside, and in which personal services (other than merely board) are provided in conjunction with residing in the setting. To qualify as a small residential community care setting, at least one resident must receive home and community care under this benefit.

2. Small nonresidential community care setting. A small nonresidential community care setting is defined as a facility in which an organized program is operated (by the facility or on the premises of the facility) which serves between 3 and 8 individuals, at least one of which receives home and community care under this benefit at the setting.

3. Large residential community care setting. A large residential community care setting is a facility in which more than 8 unrelated adults reside, and in which personal services are provided in conjunction with residing in the setting. To qualify as a large residential community care setting, at least one resident must receive home and community care under this benefit.

4. Large nonresidential community care setting. A large nonresidential community care setting is defined as a facility in which an organized program is operated (by the facility or on the premises of the facility) which serves more than 8 individuals, at least one of which receives home and community care under this benefit at the setting.

5. Unrelated adults. Unless defined differently under State law, for purposes of this benefit, unrelated adults are individuals who are 13 years of age or older, and who do not have any of the following relationships to other adults resident in the facility: spouses, parent (including stepparent) or child (including stepchild), or siblings.

6. Personal services. Personal services are those services provided to the individual by the setting, which are intended to compensate for the absence, loss, or diminution of a physical or cognitive function. Personal services, as defined here, are not equated with personal care services available under either 42 CFR 440.170, or personal care services provided under the home and community care benefit.

b. The State will provide home and community care to individuals in the following settings:

1. _____ Nonresidential settings that serve 3 to 8 people.

2. _____ Residential settings that serve 3 to 8 people, and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

3. _____ Nonresidential settings that serve more than 8 people.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

COMMUNITY CARE SETTINGS-GENERAL (con't)

4. _____ Residential settings that serve more than 8 people, and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

5. _____ Not applicable. The State will not provide services in these types of community care settings.

c. The State assures that the requirements of sections 1929(g) and (h) of the Act (as applicable to the specific setting) will be met for each setting in which home and community care is provided under this section.

d. FFP will not be claimed for home and community care which is provided in settings which have been found not to meet the requirements of sections 1929(g) and (h) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to small nonresidential community care settings.

The State will require that small nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed –

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

11. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

12. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A small nonresidential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, Legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

g. Each small nonresidential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each small nonresidential community care setting must meet any applicable State and local certification or license, zoning, building and housing codes, and State and local fire and safety regulations.

i. Each small nonresidential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients.

j. Nothing in this section shall be construed to require a small nonresidential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the facility.

k. Except to the extent dictated otherwise by State law, a small nonresidential community care setting shall not be held responsible for actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON
SMALL RESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to small nonresidential community care settings.

The State will require that small nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed –

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups. This shall not be construed to require the setting to furnish a private bedroom for the individual.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to receive notice before the room or the roommate of the resident in the setting is changed.

11. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

12. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

13. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or 'modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A small residential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of a1: financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the clients other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

g. Each small residential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each small residential community care setting must meet any applicable state and local, certification, licensure, zoning, building and housing codes, and State and local fire and safety regulations.

i. Each small residential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of residents.

j. Nothing in this section shall be construed to require a small residential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the setting.

k. Except to the extent dictated otherwise by State law, a small residential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to large nonresidential community care settings.

The State will require that large nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have teen adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed –

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

11. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

12. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plans of remedial action in effect with respect to the facility.

b. In the case of an individual adjudged incompetent under the laws of the state, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A large nonresidential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

c. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

d. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1511(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

e. Each large nonresidential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

f. Each large nonresidential community care setting must be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients, personnel and the general public.

g. Nothing in this section shall be construed to require a large nonresidential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the facility.

h. Except to the extent dictated otherwise by State law, a large nonresidential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

i. A large nonresidential community care setting must be licensed or certified under applicable State and local law.

j. A large nonresidential community care setting must meet such provisions of the most recent edition of the Life Safety Code of the National Fire Protection Association as are applicable to the type of setting.

1. The State requests that HCFA waive certain provisions of this Code, which if rigidly applied would result in unreasonable hardship upon a setting. The State certifies that such a waiver would not adversely affect the health and safety of clients or personnel. The specific request for waiver and supporting documentation are attached.

_____ Yes _____ No

2. The State certifies to HCFA that there is in effect a fire and safety code, imposed by State law, which adequately protects clients and personnel in certain types of nonresidential community care settings. The specific types of settings are identified in attached documentation. The State requests that the provisions of the State code be substituted for those of the Life Safety Code of the National fire Protection Association for those particular settings.

_____ Yes _____ No

k. Each large nonresidential community care setting must disclose persons with an ownership or control interest (including such persons as defined 'n section 1124(a)(3) of the Social Security Act) in the setting.

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State WASHINGTON

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

1. A large nonresidential community care setting may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under Medicaid or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard, or to have failed to meet the requirements of this Appendix.

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LARGE RESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to large residential community care settings.

The State will require that large residential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed –

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups. This shall not be construed to require the setting to furnish a private bedroom for the individual.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

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LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to receive notice before the room or the roommate of the resident in the setting is changed.

11. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

12. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

13. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or 'modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A large residential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

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LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

4. Permit reasonable access to a client by any entity or individual that provides health, social, Legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

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LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

g. Each large residential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each large residential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients, personnel and the general public.

i. Nothing in this section shall be construed to require a large residential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the setting.

j. Except to the extent dictated otherwise by State law, a large residential community care setting shall not be held responsible for actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

k. A large residential community care setting must be licensed or certified under applicable State and local law.

l. A large residential community care setting must meet such provisions of the most recent edition of the Life Safety Code of the National Fire Protection Association as are applicable to the type of setting.

1. The State requests that HCFA waive certain provisions of this Code, which if rigidly applied would result in unreasonable hardship upon a setting. The State certifies that such a waiver would not adversely affect the health and safety of clients or personnel. The specific request for waiver and supporting documentation are attached.
_____ Yes _____ No

2. The State certifies to HCFA that there is in effect a fire and safety code, imposed by State law, which adequately protects clients and personnel in certain types of residential community care settings. The specific types of settings are identified in attached documentation. The State requests that the provisions of the State code be substituted for those of the Life Safety Code of the National fire Protection Association.
_____ Yes _____ No

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LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

m. Each large residential community care setting must disclose persons with an ownership or control interest (including such persons as defined in section 1124(a)(3) of the Social Security Act) in the setting.

n. A large residential community care setting may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under Medicaid or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard, or to have failed to meet the requirements of this Appendix.

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Name and address of State Administering Agency, if different from the State Medicaid Agency:

The State Medicaid Agency will limit the number of PACE enrollees to 300.

I. Eligibility

_____ The State determines eligibility for PACE enrollees under rules applying to community groups.

A. _____ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. _____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II C - Compliance and State Monitoring of PACE.)

C. __X__ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

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Regular Post Eligibility

1. __X__ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

   (a) Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

      1. Allowances for the needs of the:
         (A) Individual (check one)
            1. _____ The following standard included under the State plan (check one):
               (a) _____ SSI
               (b) _____ Medically Needy
               (c) _____ The special income level for the institutionalized
               (d) _____ Percent of the Federal Poverty Level: _____%
               (e) _____ Other (specify): _____

            2. _____ The following dollar amount: $_____
               Note: If this amount changes, this item will be revised.

            3. __X____ The following formula is used to determine the needs allowance.
               (a) 100% of Federal Poverty Level
               (b) An allowance for the payment of guardianship fees of an individual under a Superior Court order of guardianship as allowed under Washington Administrative Code (WAC).

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

         (B) Spouse only (check one):
            1. _____ SSI Standard
            2. _____ Optional State Supplement Standard

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3. _____ Medically Needy Income Standard
4. _____ The following dollar amount: $_____
5. _____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
6. _____ The amount is determined using the following formula:
   _____
   _____
7. __X__ Not applicable (N/A)

(C) Family (check one):
1. _____ AFDC Need Standard
2. _____ Medically Needy Income Standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. _____ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
4. _____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5. _____ The amount is determined using the following formula:
   _____
   _____
6. _____ Other
7. __X__ Not applicable (N/A)

(2) Medical and remedial care expenses in 42 CFR 435.726.

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Regular Post Eligibility

2. _____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735**--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
   (A) Individual (check one)
      1. _____ The following standard included under the State plan (check one):
      (a) _____ SSI
      (b) _____ Medically Needy
      (c) _____ The special income level for the institutionalized
      (d) _____ Percent of the Federal Poverty Level: _____%
      (e) _____ Other (specify): _____

2. _____ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.

3. _____ The following formula is used to determine the needs allowance:
   _____
   _____

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3**.

   (B) Spouse only (check one):
      1. _____ The following standard under 42 CFR 435.121:
      _____
      2. _____ The Medically Needy income standard
      _____

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3. _____ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
4. _____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5. _____ The amount is determined using the following formula:
   _____
   _____
6. _____ Not applicable (N/A)

(C) Family (check one):
1. _____ AFDC need standard
2. _____ Medically Needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. _____ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
4. _____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5. _____ The amount is determined using the following formula:
   _____
   _____
6. _____ Other
7. _____ Not applicable (N/A)

(b) Medical and remedial care expenses in 42 CFR 435.735.

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Spousal Post Eligibility

3. _X_ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

   (a) Allowances for the needs of the:
      1. Individual (check one)
         (A) _____ The following standard included under the State plan (check one):
            1. _____ SSI
            2. _____ Medically Needy
            3. _____ The special income level for the institutionalized
            4. _____ Percent of the Federal Poverty Level: _____%
            5. _X_ Other (specify):
               - *Institutions:* $51.62 for single or $103.24 for a couple.
               - *Community residential facility*: MNIL
               - *Home:* MNIL for single (with community spouse) 100% of Federal Poverty Level for married couple, both on PACE.

         (B) _____ The following dollar amount:

         (C) _____ The following formula is used to determine the needs allowance:
         _____
         _____

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If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____

_____

_____

II. Compliance and State Monitoring of the PACE Program

For State Medicaid Agencies also serving as PACE State Administering Agencies, the State further assures all requirements of section 1934 of the Social Security Act will be met. All relevant provisions are included in the contract with the PACE entities, either as contractor or State responsibility. Both scheduled and unscheduled on-site reviews will be conducted by State staff.

A. Readiness Review: The State will perform a Readiness Review of the applicant entity that assures the entity has fully developed its policies and procedures, obtained commitments from key staff, developed its solvency plan and has a facility that meets State and Federal requirements at the time of the application, in accordance with Section 460.12(b)(1).

B. Monitoring During Trial Period: During the trial period, the State, in cooperation with CMS, will conduct comprehensive reviews of a PACE organization to ensure compliance with State and federal requirements.

At the conclusion of the trial period, the State, in cooperation with CMS, will continue to conduct reviews of a PACE organization, as appropriate, taking into account the quality of care furnished and the organization's compliance with State and federal requirements.

C. Annual Monitoring: The State assures that at least annually it will reevaluate whether a participant meets the level of care required under the State Medicaid plan for coverage of nursing facility services. The State understands that this determination may be waived if there is no reasonable expectation of improvement or significant change in the participant's conditions because of the severity of a chronic condition or the degree of impairment of functional capacity.

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D. Monitoring of Corrective Action Plans: The State assures it will monitor the effectiveness of corrective actions required to be taken by the PACE organization.

III. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those with fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

Rate Methodology
Actual fee-for-service date for calendar year 2001, after comparison with calendar year 2000 data and adjusted, was trended forward by adding the various vendor rate increases authorized by the legislature. Data was initially arrayed based on gender, age in 10-year increments, Medicare eligibility (Medicaid only and dual eligibility) service program (nursing home or HCBS) and service type (acute and long-term care). Only services received by persons eligible for nursing facility services or HCBS, residing in King County, age 55 and over were included in the base data.

The following four groups, as approved by CMS, will be used to determine payment for PACE:

Medicaid Eligible Only, age 64 and under;
Medicaid Eligible Only, age 65 and above;
Medicaid & Medicare Eligible, age 64 and under;
Medicaid & Medicare Eligible, age 64 and above.

1. _X_ Rates are set at a percent of fee-for-service costs
2. _____ Experience-based (contractors/State's cost experience or encounter date) (please describe) – See rate methodology above
3. _____ Adjusted Community Rate (please describe)
4. _____ Other (please describe)

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B. _X_ The rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.
Actuary Tim Barclay, from Milliman USA, Incorporated, 1301 Fifth Avenue, Suite #3600, Seattle, WA 98101-2605 is responsible for determining the rates to be reasonable and predictable.

C. _X_ The State will submit all capitated rates to the CMS Regional Office for prior approval.

A. IV. Enrollment and Disenrollment: For both State Medicaid Agencies and State Administering Agencies, the State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month. In cases where the State Medicaid Agency is separate from the State Administering Agency, the State Medicaid Agency assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the two agencies.

Enrollment Process (please describe):

The State Administering Agency assesses any potential participant including those who are not eligible for Medicaid to ensure that the individual meets the nursing facility level of care. Eligible individuals may enroll the first of the month following the date the PACE organization received the signed enrollment agreement. The agency will conduct a face-to-face reassessment of PACE clients every twelve (12) months and/or whenever the client's circumstances or physical condition substantially changes.

Medicaid Eligible Only, age 64 and under;
Medicaid Eligible Only, age 65 and above;
Medicaid & Medicare Eligible, age 64 and under;
Medicaid & Medicare Eligible, age 65 and above.

1. _X_ Rates are set at a percent of fee-for-service costs
2. _____ Experience-based (contractors/State's cost experience or encounter date) (please describe) – See rate methodology above
3. _____ Adjusted Community Rate (please describe)
4. _____ Other (please describe)

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B. Enrollee Information (Please describe the information to be provided to enrollees): Enrollees shall receive a copy of their CARE: Service Summary, financial award notices, and notice of fair hearing rights for any adverse actions. Enrollees are entitled to a fair hearing after it has gone through the PACE organization's internal appeal process. Medicaid fair hearing rights shall be translated for individuals with limited English proficiency.

The State assures that the following information is provided to all enrollees prior to and at the time of enrollment and annually thereafter, by the PACE organization in accordance with its approved policies and procedures.

Detailed information about 460.112, Participant Rights, 460.120, 460.122, Grievance and Appeals processes; 460.154, Enrollment Agreement; and 460.156, Other enrollment procedures are contained in the Participant Handbook of which the Enrollment Agreement is a part.

The process for explaining the information contained in the Participant Handbook, in a manner understandable to the enrollee, is conducted in the following manner:

In accordance with Policy Number 301.03, issued 7/13/01, the process begins with a contact by telephone or in-person between the potential participant and the PACE Intake Coordinator. The Intake Coordinator, after making an initial determination of eligibility, arranges a home visit. During the home visit, the Intake Coordinator explains the PACE organization using the Participant Handbook and answers any questions from the individual and/or caregiver. If the individual is interested in joining, a site visit is arranged at which time the individual meets with members of the multidisciplinary team and again is provided with opportunities to ask questions.

At this time, the Intake Coordinator contacts the Aging and Disability Services Administration (ADSA) Home and Community Services (HCS) office to start the process of determining functional and financial eligibility for individuals requesting Medicaid coverage, or to determine functional eligibility only for individuals who pay privately.

If the individual is determined to be eligible and if the individual agrees to accept the program conditions, he/she signs an enrollment agreement in accordance with Policy 301.04, issued 7/13/01 which requires that all individuals who enroll in PACE must sign an enrollment agreement. Prior to signing, the Intake Coordinator again reviews the Participant Handbook with the individual and he/she receives a copy of the Handbook for reference.

All enrollees also receive a PACE enrollment card in accordance with the requirements in 460.156.

The State undertakes the following steps:

At the time of enrollment, the HCS case manager sends the PACE organization proof of nursing home certification contained in the CARE Assessment document. HCS will send proof of recertification on an annual basis. In addition, the HCS case manager provides the authorization for enrollment for Medicaid recipients and calculates the monthly participant fee for the enrollee, if any.

C. Disenrollment Process (Please describe - voluntary and involuntary): The PACE organization will notify the state of involuntary disenrollments after the organization has followed its approved internal process. The state will respond within five business days of receiving the request for a review. The state will notify the enrollee of the adverse action and, the right to a fair hearing. Enrollees may choose to voluntarily disenroll from PACE at any time of the month. The state will assist with returning any disenrolled participant (voluntary or involuntary) to the previous Medicaid coverage program, effective the beginning of the next month possible.

The PACE organization follows Policy Number 302.1 for Voluntary Disenrollments:

All participants have the right to voluntarily disenroll from the PACE organization without cause at any time. Once the participant has notified the PACE organization staff that he/she wishes to disenroll, either in person or in writing, members of the multidisciplinary team work with the participants to see if the reasons(s) for disenrolling can be resolved. If there is no resolution, the PACE

Social Worker has the individual or his/her caregiver sign the disenrollment form. The disenrollment form advises participants of the following:

- They may be contacted by HCS or CMS to verify their desire to disenroll
- Attests to the fact that they understand that they are disenrolling and
- That they have been informed that they will return to the traditional Medicare and Medicaid systems as of the disenrollment date and no longer are required to receive services through the PACE organization.

The social worker notifies the multidisciplinary team and the HCS case manager and financial worker regarding the anticipated date for disenrollment. The effective date of disenrollment will be the last day of the month administratively possible using the most expedient process available. The multidisciplinary team ensures that the participant is reinstated in other Medicare and Medicaid programs after disenrollment by making appropriate referrals, transferring medical records and coordinating with CMS and HCS to ensure participant's reinstatement. All services to the participant are continued during the disenrollment process.

The social worker sends the official disenrollment letter to the participant and his/her representative and the nursing home, if the participant is currently residing there. The social worker also notifies the PACE organization business office. The Accounting Assistant in the business office will remove the participant's name from the billing cycle and will report the disenrollment to CMS.

HCS undertakes the following steps:

An HCS representative may contact the former enrollee to verify his/her desire to disenroll.

D. The State assures that before an involuntary disenrollment is effective, it will review and determine in a timely manner that the PACE organization has adequately documented grounds for disenrollment.

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E. In the event a PACE participant disenrolls or is disenrolled from a PACE program, the State will work with the PACE organization to assure the participant has access to care during the transitional period.

F. The State assures it will facilitate reinstatement in other Medicaid/Medicare programs after a participant disenrolls.

G. The State assures that the State PACE requirements and State procedures will specify the process for how the PACE organization must submit participant information to the State.

VI. Marketing: For State Medicaid Agencies also acting as PACE State Administering Agencies, the State assures that a process is in place to review PACE marketing materials in compliance with Section 460.82(b)(ii).

VII. Services: The following items are the medical and remedial services provided to the categorically needy and medically needy. (Please specify): All services as allowed under the Washington State Medicaid State Plan, in Section 3.1A.

The State assures that the State agency that administers the PACE program will regularly consult with the State Agency on Aging in overseeing the operation of the PACE program in order to avoid service duplication in the PACE service area and to assure the delivery and quality of services to PACE participants.

VIII. Decisions that require joint CMS/State Authority

A. For State Medicaid Agencies also acting as PACE State Administering Agencies, waivers will not be granted without joint CMS/State agreement:

1. The State will consult with CMS to determine the feasibility of granting any waivers related to conflicts of interest of PACE organization governing board members.

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2. The State will consult with CMS to determine the feasibility of granting any waivers related to the requirements that: members of the multidisciplinary team are employees of the PACE organization; and that members of the multi- disciplinary team must serve primarily PACE participants.

B. Service Area Designations: The State will consult with CMS on changes proposed by the PACE organization related to service area designation.

C. Organizational Structure: The State will consult with CMS on changes proposed by the PACE organization related to organizational structure.

D. Sanctions and Terminations: The State will consult with CMS on termination and sanctions of the PACE organization.

IX. State Licensure Requirements

For State Medicaid Agencies also acting as PACE State Administering Agencies, the State assures that Life Safety Code requirements are met for facilities in which the PACE organization furnishes services to PACE participants in accordance with Section 460.72(b), unless CMS determines that a fire and safety code imposed by State law adequately protects participants and staff.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

The following ambulatory services are provided. *

Outpatient hospital services

Clinic services

Other laboratory services

Home health services

Physicians' services

Prescribed drugs, dentures, prosthetic devices and eyeglasses

Family planning services

*Description provided on attachment.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

1. Inpatient hospital services other than those provided in an institution for mental diseases.

__X__ Provided: ____ No limitations __X__ With limitations*

2.a. Outpatient hospital services.

__X__ Provided: ____ No limitations __X__ With limitations*

d. Rural health clinic services and other ambulatory services furnished.

_X_ Provided: _X_ No limitations ___ With limitations*

e. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

_X_ Provided: _X_ No limitations ___ With limitations*

3. Other laboratory and x-ray services.

__X_ Provided: ___ No limitations _X_ With limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

__X__ Provided: ____ No limitations __X__ With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

__X__ Provided

c. Family planning services and supplies for individuals of childbearing age.

__X__ Provided: __X__ No limitations ____ With limitations*

*Description provided on attachment.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

__X__ Provided: ____ No limitations __X__With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

__X__ Provided: ____No limitations __X__With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

__X__ Provided: ____ No limitations __X__With limitations*

Not Provided: ____

b. Optometrists' services.

__X__ Provided: ____No limitations __X__With limitations*

Not Provided: ____

c. Chiropractor's services.

____ Provided: ____No limitations ____With limitations*

Not Provided: __X__

d. Other practitioners' services. Identified on attached sheet with description of limitations, if any.

__X__ Provided: ____No limitations __X__With limitations*

Not Provided: ____

*Description provided on attachment.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

__X__ Provided: ____No limitations __X__With limitations*

b. Home health aide services provided by a home health agency.

__X__ Provided: ____No limitations __X__With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

__X__ Provided: ____ No limitations __X__ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

__X__ Provided: ____ No limitations __X__ With limitations*

e. Other Medical services, supplies, equipment and appliances.

__X__ Provided: ____ No Limitations __X__ With limitations*

8. Private duty nursing services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

9. Clinic services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

*Description provided on attachment.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

10. Dental services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

11. Physical therapy and related services.

a. Physical therapy.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

b. Occupational therapy.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

__X__ Provided: ____ No Limitations __X__ With limitations*

Not Provided: ____

12. Prescription drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

*Description provided on attachment.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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12. Prescription drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist. (continued)

b. Dentures.

__X__ Provided: ____ No limitations __X__ With limitations*

c. Prosthetic devices.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

d. Eyeglasses.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: _X___

b. Screening services.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

c. Preventive services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

*Description provided on attachment.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. (continued)

d. Rehabilitative services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

b. Nursing facility services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

c. Intermediate care facility services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

15.a. Intermediate care facility services for individuals with developmental disabilities who are determined in accordance with section 1902(a)(31) of the Act, to be in need of such care.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

*Description provided on attachment.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

15.b. Including such services in a public institution (or district part thereof) for the mentally retarded or persons with related conditions.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

16. Inpatient psychiatric facility services for individuals under 21 years of age.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

17. Nurse -midwife services.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

18 Hospice care (in accordance with section 1903(o) of the Act.

__X__ Provided: ____ No limitations __X__ With limitations*

Not Provided: ____

19 Case management services and Tuberculosis related services.

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

__X__ Provided: ____ With limitations*

Not Provided: ____

*Description provided on attachment.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

19. Case management services and Tuberculosis related services. (continued)

b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.

____ Provided: ____ With limitations*

Not Provided: _X__

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

__X__ Provided: _____ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

__X__ Provided __X__ Additional coverage ++

21. Certified pediatric or family nurse practitioners' services.

__X__ Provided __X__ No limitations ____ With limitations*

Not Provided: ____

* Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

** Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act.

__X__ Provided: ____ No limitations __X__ With limitations

Not Provided: ____

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

__X__ Provided: ____No limitations __X__ With limitations*

Not Provided: ____

b. Services provided in religious non-medical health care facilities.

____ Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

c. Reserved.

____Provided: ____ No limitations ____ With limitations*

Not Provided: __X__

d. Nursing facility services for residents under 21 years of age.

__X__ Provided: ____ No limitations __X__With limitations*

Not Provided: ____

e. Emergency hospital services.

__X__ Provided: __X__ No limitations ____ With limitations*

Not Provided: ____

*Description provided on attachment.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

24. Home and Community Care for Functionally Disabled elderly individuals, as defined, described and limited in Supplement 2 to attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ Provided: __X__ Not Provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

____ Provided: ____ State Approved (Not Physician) Service Plan Allowed

____ Services Outside the Home Also Allowed

____ Limitations Described on Attachment

_X_ Not Provided.

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A

_____ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan Service.

__X__ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

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DESCRIPTION OF LIMITATION OF SERVICES

1. Inpatient hospital services

   a. Prior authorization is required for psychiatric inpatient care.

   b. Chronic pain management is limited to inpatient services provided by Department of Social and Health Services (department) approved pain centers in a hospital.

   c. Long-term acute care services are provided in department-approved hospitals and require prior authorization. This is not sub-acute care; rather this is intensive acute inpatient care provided to patients who would otherwise remain in intensive care or a similar level of care outside of a hospital's intensive care unit.

2. a. Outpatient hospital services

      (1) Hospital-owned institutional facilities that are hospital-based may provide outpatient hospital services to eligible clients when authorized by the department to do so.

      (2) Freestanding hospital-owned institutional facilities that are nonhospital-based may provide outpatient hospital services to eligible clients when authorized by the department to do so.

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3. Other laboratory and x-ray services

a. Laboratory services

Pathology services are considered to be the same as laboratory services. The department covers all these services that are inpatient hospital. Limitations shown below are for outpatient.

Drug screens only when medically necessary and when:

- Ordered by a physician as part of a medical evaluation; or
- As drug and alcohol screens required to assess suitability for medical tests or treatment. For opiate substitution and pregnant women clients in the department's contracted treatment programs, drug screens for monitoring alcohol/drug use are reimbursed through a contract issued by the department.

One each of the following, per client per day:

- Blood draw fee; and
- Catheterization for collection of urine specimen.

b. Radiology services

The department covers all these services that are inpatient hospital. Limitations shown below are for outpatient.

The following services require prior approval through the Expedited Prior Authorization (EPA) process:

- Outpatient magnetic resonance imaging (MRI);
- Positron Emission Tomography (PET) scans;
- More than one annual screening mammogram for clients forty (40) years of age and older (based on the National Cancer Institute (NCI) recommendations regarding screening mammograms); and
- General anesthesia for radiological procedures. Allowed only when the medically necessary procedures cannot be performed unless the client is anesthetized.

Portable x-ray services furnished in the client's home or a nursing facility are limited to films that do not involve the use of contrast media.

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4. a. Nursing facility services

Prior approval of admission

b. Early and periodic screening, diagnosis, and treatment

Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a program providing EPSDT to persons under 21 years of age who are eligible for Medicaid or the Children's Health Program. In conformance with 1905(r) of the Act, all medically necessary diagnosis and treatment services are provided regardless of whether the service is included in the plan. Limitations do not apply other than based on medical necessity.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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5. a. Physicians' Services

Exceptions for noncovered services and service limitations are allowed when medically necessary and prior authorized by the department.

(1) Critical care.

- A maximum of three hours of critical care per client per day.
- For inpatient critical care, only the attending physician(s) who assume(s) responsibility for care of the client during a life threatening episode is/are reimbursed.
- More than one physician may be reimbursed if the services provided involve multiple organ systems (unrelated diagnosis).
- In the emergency room, only one physician is reimbursed.

(2) Hospital visits. No payment for visits on those days that exceed the allowed length of stay unless an extension was requested and has been approved.

(3) Newborn care and neonatal intensive care unit (NICU) services.

- One routine NICU visit per client per day.
- Prolonged care and newborn resuscitation when the physician is present at the delivery (in addition to the one routine visit).

(4) Osteopathic manipulative therapy.

Up to ten osteopathic manipulations per client, per calendar year.

(5) Physical exams:

Routine physical exams are covered in specific instances, including but not limited to:

- EPSDT screening
- Nursing facility placement exams
- Disability determinations for Title XVI-related individuals
- Yearly exams for developmental disability determination (DDD) clients

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5. a. Physicians' services (cont.)

(6) Physician care plan oversight.

Provided once per client, per month. A plan of care must be established by the home health agency, hospice, or nursing facility, and the physician must provide 30 minutes or more of oversight each calendar month to the client.

(7) Physician standby services.

Must be:

- Requested by another physician; and
- Involve prolonged physician attendance without direct (face-to-face) patient contact.

The service must exceed 30 minutes.

(8) Physician visits.

Limited to:

- Two physician visits per month for a client residing in a nursing facility or an intermediate care facility.
- One inpatient hospital visit per client, per day, for the same or related diagnosis.
- One office or other outpatient visit per non-institutionalized client, per day, for an individual physician, except for return visits to an emergency room.

Professional inpatient services during the follow-up period are only paid if they are performed on an emergency basis and are unrelated to the original surgery.

(9) Psychiatric services:

- Outpatient psychotherapy and electroconvulsive therapy, in any combination - one hour per day, per client, up to a total of twelve hours per calendar year. Includes family or group psychotherapy.
- Psychiatric diagnostic interview examinations - one in a calendar year unless a new mental health diagnosis occurs.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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5. b. Medical and surgical services furnished by a dentist

Short stay procedures also take place in ambulatory surgery settings.

(1) Nonemergent oral surgeries performed in an inpatient hospital setting are not covered. The exception to this are DDD clients and children 18 years of age and under, whose surgery cannot be performed in an office setting (e.g., orthognathic cleft palate bone grafting). Prior written authorization is required. Documentation must be maintained in the client's record.

(2) Orthodontic treatment is limited to medically necessary treatment, as follows, and only for children with severe handicapping malocclusion, craniofacial anomalies or cleft lip or palate:

(a) Clients in the EPSDT program through age twenty (20);

(b) Clients in the children's health program through age eighteen (18); and

(c) Clients in the MN program through age twenty (20).

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law

a. Podiatrists' services

(1) Foot care is covered only for specific medical conditions that must be treated by an M.D., D.O., or podiatrist.

(2) The treatment of flat feet, or non-medically necessary treatment of fungal disease is not covered.

b. Optometrists' services

(1) Frames, lenses, and contact lenses must be ordered from the department's contractor.

c. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law (continued)

(1) MAA covers medically necessary eye examinations, refractions, eyeglasses (frames and glasses), and fitting fees as follows:

- Every 24 months for asymptomatic adults 21 years or older; and
- Every 12 months for asymptomatic children 20 years or younger, and clients identified by MAA as developmentally disabled.

(2) The department covers medically necessary contact lenses, as defined in rule. Normal replacement for contact lenses is every 12 months.

(3) Exceptions to numbers (1) and (2) above will be considered for all individuals based on medical necessity.

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6. d. Other practitioners' services

All other practitioners covered by the department include, but are not limited to, the following licensed practitioners: psychologists, respiratory therapists, certified pediatric/family nurse practitioners, advanced registered nurse practitioners, dental hygienists, denturists, chiropractors (for EPSDT only), dietitians, nutritionists, occupational therapists, pharmacists, physical therapists, podiatrists, radiological technicians, speech/language pathologists, audiologists, licensed non-nurse midwives, birthing centers, and registered nurses first assistants. These practitioners are limited to services within their scope of practice.

Counselors, social workers, and other practitioners are covered as specified in other sections of the State Plan and as approved by the department.

(1) MAA does not cover services provided by:

- Acupuncturists
- Christian Science practitioners or theological healers
- Herbalists
- Homeopathists
- Naturopaths
- Masseuses
- Masseurs
- Sanipractors

(2) Licensed non-nurse midwives

- To participate in home births and in birthing centers, midwives must be a MAA-approved provider.

(3) Psychologists.

- One psychological evaluation per client's lifetime is covered.
- Neuropsychological testing requires prior authorization.

(4) Registered nurse first assistants.

- Registered Nurse First Assistants (RNFA) must provide services under the direction of a performing surgeon.

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6. d. Other practitioners' services (cont.)

(5). Freestanding Birthing centers.

Definition: A freestanding birthing center is a specialized facility licensed as a childbirth center by the State's Department of Health (DOH).

- The DOH licensed birthing centers that have a core provider agreement with the department are authorized to provide necessary facility services.
- Eligible clients must meet medical criteria.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

7. Home health services

a. Intermittent or part-time nursing services

(1) Applies to home health agency and to services provided by a registered nurse when no home health agency exists in the area.

(2) Approval required when period of service exceeds limits established by the single state agency.

(3) Nursing care services are limited to:

(a) Services that are medically necessary;

(b) Services that can be safely provided in the home setting;

(c) Two visits per day (except for the services listed below);

(d) Three obstetrical visits per pregnancy for high risk pregnancy clients; and

(e) Infant home phototherapy that was not initiated in the hospital setting.

(4) Exceptions are made on a case-by-case basis.

Approval required when period or services or total monthly reimbursement exceeds limits established by the single state agency. Applies to home health agency and to services provided by a registered nurse when no home health agency exists in area.

b. Home health care services provided by a home health agency

Home health aide services must be:

(1) Intermittent or part time;

(2) Ordered by a physician on a plan of care established by the nurse or therapist;

(3) Provided by a Medicare-certified home health agency;

(4) Limited to one medically necessary visit per day; and

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7. Home health services (cont.)

(5) Supervised by the nurse or therapist biweekly in the client's home.

(6) Exceptions are made on a case-by-case basis.

c. Medical supplies, equipment and appliances suitable for use in the home

Medical supplies, equipment and appliances must be:

(1) Medically necessary;

(2) Ordered by the treating physician; and

(3) In the plan of care.

All of the following apply to durable medical equipment (DME) and related supplies, prosthetics, orthotics, medical supplies and related services suitable for use in the home:

(1) Purchase of equipment and appliances and rental of durable medical equipment require prior approval.

(2) Must be billed separately under a DME provider number.

(3) Are subject to the requirements in Washington Administrative Code.

(4) Specific reusable and disposable medical supplies, prosthetics, orthotics, and non-durable equipment which have set limitations, require prior approval (PA) to exceed those limitations.

d. Other Medical services supplies, equipment and appliances

(1) The Oxygen and Respiratory Therapy Services Program provides medically necessary oxygen and/or respiratory therapy equipment, services, and supplies to eligible clients who reside at home, when the services are medically necessary.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

7. d. Home health services (cont.)

(2) Home infusion-parenteral nutrition equipment and supplies are provided when medically necessary.

- One germicide and/or one antiseptic allowed on the same day. Justification for exceeding this limit must be documented in the client's file.

(3) The Medical Nutrition Program provides medically necessary nutrition and related equipment and supplies, when the client is unable to meet daily nutritional requirements using traditional foods alone, due to injury or illness.

Limitations described below do not apply to the Medical Nutrition Program for EPSDT purposes. Exceptions to these limitations are based on medical necessity.

- A licensed and certified dietitian must evaluate all clients 20 years of age and younger within 30 days of initiation of medical nutrition, and periodically (at the discretion of the licensed/certified dietitian) while the client is receiving medical nutrition.
- Initial assessments limited to 2 hours (or 8 units) per year.
- Reassessments limited to no more than 1 hour (or 4 units) per day.
- Group therapy limited to 1 hour (or 4 units) per day.

e. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility

(1) Provided by a Medicare-certified home health agency. A medical rehabilitation facility must subcontract with a Medicare-certified home health agency in order to provide services in the client's home and bill for those services.

(2) Limited to clients who cannot receive their medically necessary care in the community, and meet one of the following:

(a) The client has an acute care need, has not attained a satisfactory level of rehabilitation, and requires frequent intervention; or

(b) The client is not medically stable.

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

8. Private duty nursing services

The purpose of the Private Duty Nursing (PDN) Program is to reduce the cost of healthcare services by providing equally effective, more conservative, and/or less costly treatment in a client's home. The department's Medical Assistance Administration has oversight for the program for clients 17 years of age or younger. Eligible clients must meet all of the following: be 17 years of age or younger; need continuous skilled nursing care that can be provided safely outside an institution; and have prior authorization from the department. PDN Program services for those age 18 and older are administered by the department's Aging and Disability Services Administration, and are comparable to services for those under age 18.

The department contracts with State licensed home health agencies to provide PDN services. Within the home health agency, private duty nursing services must be performed by a licensed and appropriately trained registered nurse and/or a licensed practical nurse. For persons 18 years and older with an approved exception to policy, a private (non-home health agency) RN or LPN under the direction of a physician can provide PDN services only when the geographic location precludes a contracted home health agency from providing services, or when no contracted home health agency is willing to provide PDN services.

PDN services meet complex medical needs for persons who require at least four continuous hours of skilled nursing services on a day-to-day basis. Services provide alternatives to institutionalization in a hospital or nursing facility and are not intended to supplant or replace other means of providing the services.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

9. Clinic services

f. Freestanding kidney centers

(1) Description of facility: A center devoted specially to treating End Stage Renal Disease (ESRD)

(2) Description of service: Peritoneal dialysis or hemodialysis for ESRD.

(3) Program coverage: Covered as an outpatient service when provided by a freestanding renal dialysis center or a freestanding community hemodialysis unit. Includes physician services, medical supplies, equipment, drugs, and laboratory tests.

(4) Prior authorization: Required for the facility but not the physician. Initial authorization may be granted for up to three months. Reauthorization may be granted for up to twelve months.

(5) Reimbursement: This service is reimbursed according to attachment 4.19-B, II, A.

b. Freestanding ambulatory surgery centers

Allowed procedures are covered when they:
- Are medically necessary; and
- Are not for cosmetic treatment surgery.

Some procedures are covered only when they:

- Meet certain limitation requirements; and
- Have been prior authorized by the department.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

10. Dental services and dentures

a. Limited to selected medically necessary services for the identification and treatment of dental problems or the prevention of dental diseases. Some of these services may require prior authorization.

b. Crowns are covered only for children through age twenty (20) and require prior authorization.

c. Orthodontic treatment is limited to medically necessary treatment, as follows, and only for children with craniofacial anomalies or cleft lip or palate or severe handicapping malocclusion. Limits may be exceeded based on medical necessity.

(1) Clients in the EPSDT program through age twenty (20);
(2) Clients in the MN program through age twenty (20).

d. Clients of the Developmental Disability Division may receive additional services.

e. Dentures

(1) For limitations indicated in (1) below, limits may be exceeded based on medical necessity. (1) For clients through age twenty (20), allowed per client:

- Complete, immediate, and overdenture dentures - one maxillary and one mandibular denture in a ten year period.
- Partial dentures - once every five years, subject to limitations.
- Replacement full or partial dentures - requires prior authorization when requested within one year of the seat date of the previous dentures.
- Rebase - once every five years and the dentures must be at least three years old
- Relines and adjustments - included in the reimbursement if done within six months of the seat date. After six months, allowed once every five years.

(2) For clients age twenty-one (21) and over, allowed per client:

- Immediate dentures - one maxillary and one mandibular denture in a lifetime, and requires prior authorization.
- Complete dentures - one maxillary and one mandibular denture in a ten-year period and requires prior authorization.
- Resin and cast metal framework partial dentures - once in a ten-year period and requires prior authorization.
- Replacement resin partial dentures – not allowed within the ten-year period.
- Replacement cast metal framework partial dentures - once in a ten-year period.
- Complete and partial denture relines - once in a five-year period.

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11. Physical therapy and related services

a. Duplicate services for occupational, physical, and speech therapy are not allowed for the same client when providers are performing the same or similar procedure(s).

b. Prior authorization required to exceed set limits for clients twenty-one (21) years of age and older as follows:

(1) Prior Authorization is required for physical therapy (PT) when the client:
- Is 21 years of age and older and requires services beyond one PT evaluation and 48 units PT per year, per client per diagnosis; or
- Is 21 years of age and older and has a qualifying diagnosis or has completed an approved inpatient rehab stay, and requires services beyond one PT evaluation and 144 units of PT per year, per client, per diagnosis.

(2) Prior Authorization is required for occupational therapy (OT) when the client: I
- Is 21 years of age and older and requires services beyond one OT evaluation and 12 OT visits per year, per client; or
- Is 21 years of age and older and has a qualifying diagnosis or has completed an approved inpatient rehab stay and requires services beyond one OT evaluation and 36 OT visits per year, per client.

(3) Prior Authorization is required for speech therapy (ST) when the client:
- Is 21 years of age and older and requires services beyond one Speech evaluation and 12 Speech visits per year per client; or
- Is 21 years of age and older and has a qualifying diagnosis and requires services beyond one Speech evaluation and 36 Speech visits per year per client.

c. Services for individuals with speech, hearing, and language disorders must be provided by or under the supervision of a speech pathologist or audiologist.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

12. a. Prescribed drugs

Drug Coverage

(1) Covered outpatient drugs as defined in Section 1927 (k)(2) of the Act are those which are prescribed for a medically accepted indication and produced by any manufacturer, which has entered into and complies with an agreement under Section 1927 (a) of the Act.

(2) Prescriptions written as a result of an EPSDT visit will be approved as ordered by the prescriber when that information is communicated to the Therapeutic Consultation Service (TCS) clinical pharmacists.

(3) Generic drugs, insulin and diabetic supplies, contraceptives, antipsychotics, anticonvulscants, antidepressants, chemotherapy, antiretroirals, immunosuppressants, and hypoglycemic rescue agents will be exempt from triggering a TCS review. During a TCS review, all covered outpatient drugs, as defined in Section 1927 (k) (2) of the Act are authorized for the Medicaid client, if the prescriber deems them to be medically necessary.

(4) Under Washington Administrative code, pharmacies are advised to provide an emergency supply of medically necessary drugs when TCS reviews are pending.

(5) Drugs excluded from coverage as provided by Section 1927(d)(2) of the Act, include: DESI drugs, experimental drugs, weight loss drugs (unless prescribed for an indication other than obesity), drugs for cosmetic purposes, drugs for fertility, and drugs for smoking cessation (except that Zyban is covered for pregnant or post-partum women according to Washington Administrative Code.)

Prior Authorization

(6) Prescription drugs may be subject to prior authorization by the agency to ensure that drugs are prescribed and dispensed appropriately.

(7) MAA determines which prescription drugs may require prior authorization by reviewing the drug(s) for the following:

- Safety
- Potential for abuse or misuse
- Narrow therapeutic index
- High cost when less expensive alternatives are available

(8) Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization and provides for the dispensing of at least a 72-hours supply of medications in emergency situations.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

12. a. Prescribed drugs (cont.)

Therapeutic Consultation Services (TCS)

(9) In the Therapeutic Consultation Service (TCS), all Medicaid clients will have their entire drug profile reviewed by clinical pharmacists after the fifth request for a brand-name drug is processed. A non-preferred drug is a drug in a drug class that has essentially the same clinical safety and efficacy as the drug of choice, but is not the preferred drug. TCS is not a limit, but rather a service to provide a clinical pharmacy review of the client's entire drug therapy. This review is conducted to assure that Medicaid clients are receiving appropriate drug therapy, without therapeutic duplication or without potentially serious drug-drug interactions or drug-disease conflicts. Prescribers direct clients' drug therapy and have the final say. Reports will be available that indicate the numbers of prescriptions that were dispensed as originally ordered by the prescriber.

Supplemental Rebate Agreement

(10) The state is in compliance with Section 1927 of the Act. The state will cover drugs of manufacturers participating in the Medicaid Drug Rebate Program. Based on the requirements for Section 1927 of the Act, the state has the following policies for drug rebate agreements:

- Manufacturers are allowed to audit utilization rates;
- The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with Section 1927 (b)(3)(D);
- A rebate agreement between the state and a drug manufacturer for drugs provided to the Washington Medicaid population, submitted to CMS on January 14, 2002, entitled "State of Washington Supplemental Rebate Contract" has been authorized by CMS.
- A rebate agreement between the state and a drug manufacturer for drugs provided to the Washington Medicaid population, submitted to CMS on January 16, 2004, entitled "State of Washington Supplemental Rebate Contract" has been authorized by CMS.
- The state reports rebates from separate agreements to the Secretary for Health and Human Services (HHS). The state will remit the federal portion of any cash state supplemental rebates collected on the same percentage basis applied under the national rebate agreement.
- All drugs covered by the program, irrespective of a prior authorization agreement, will comply with provisions of the national drug rebate agreement.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

12. a. Prescribed drugs (cont.)

Preferred Drug List

- Pursuant to 42 U.S.C. section 1396r-8, the State is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization, and provides for the dispensing of at least a 72-hour supply of medications in emergency situations, in accordance with provisions of section 1927(d)(5) of the Social Security Act. The prior authorization process is described in chapter 388-530 WAC.
- Prior authorization will be established for certain drug classes or particular drugs in accordance with Federal law. All drugs covered by the program, irrespective of a prior authorization requirement, will comply with the provisions of the national drug rebate agreement.
- A preferred drug list does not prevent Medicaid beneficiaries from obtaining access to medically necessary drugs of manufacturers that participate in the national drug rebate program.
- The State will utilize the Drug Utilization Review Board to assure, that in addition to pricing consideration, preferred drugs are clinically appropriate.

Mail Order Delivery Service for Prescription Drugs

(11) The state contracts for a mail-order delivery service for prescription drugs through a competitive bid process. This service is available to all fee-for-service Medicaid clients statewide. Clients have the option of having prescriptions filled at either a local retail outlet of their choice or by the mail-order contractor.

All policies and procedures that apply to retail pharmacies also apply to the mail-order contractor, except for the following:

(a) The mail-order contractor is reimbursed at a mutually agreed upon level that is less than reimbursement provided to local retail pharmacies; and

(b) If authorized by the prescriber, the mail-order contractor may dispense the following drugs in up to a ninety-day supply:

(i) Preferred drugs identified by the state;

(ii) Generic drugs; and

(iii) Drugs that do not require prior authorization or expedited prior authorization.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

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12. b. Dentures

These services have been moved under section10. Dental Services, based on CMS recommendation.

12. c. Prosthetic devices

(1) Prior approval required

(2) Hearing aids not provided to adults 21 years and older.

12. d. Eyeglasses (Included under “Optometrists’ Services”, section 6.b.)

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13. c. Preventive services

Rabies shots. Approval required.

Disease State Management

The State of Washington will provide a statewide Disease Management Program to Medicaid clients eligible for Title XIX Medicaid coverage under the Categorically Needy Program (CNP), who receive services through the Medical Assistance Administration's (MAA's) fee-for-service system, and who have one or more of the following diseases:

- Asthma;
- Congestive Heart Failure;
- Diabetes;
- End State Renal Disease (ESRD) or Chronic Kidney Disease (CKD);
- Chronic Obstructive Pulmonary Disease (COPD).

The State's Disease Management Program is designed to assist clients with chronic illness to achieve the following goals:

1. Increase the client's (and/or their caregiver's) understanding of their disease so they are:

   - More effective partners in the care of their disease;
   - Better able to understand the appropriate use of resources needed to care for their disease(s);
   - Able to identify when they are getting in trouble earlier and seek appropriate attention before they reach crisis levels; and
   - More compliant with medical recommendations.

2. Provide coordination among multiple case managers and health care providers;
3. Improve adherence to national, evidence-based guidelines to improve clients' health status; and
4. Reduce unnecessary emergency department visits and hospitalizations.

Components of Disease State Management

Contracted disease management vendors will provide the following services to clients eligible for the program:

- Outreach that is sufficient to draw hard-to-serve clients into the program, including home visits or other face-to-face contact if the client does not have a telephone, or is unable to use the telephone.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13. c. Preventive services/Disease State Management (cont.)

- Twenty-four hour-a-day, seven days-a-week (24/7) toll free nurse telephone consultation and screening service staffed by licensed registered nurses. The toll free nurse service will provide advice and consultation to all clients in the enrollment group of 173,000 on a 24/7 basis. In addition, during each incoming call, the triage nurse will ask a series of questions designed to determine if the client has one of the conditions being served by the disease management program. If the caller has one of the conditions covered by this program, he or she will be transferred to either the McKesson Care Enhance program or the Renaissance ESRD program for further assessment and risk stratification.
- Once the client has been referred for further assessment, the appropriate contractor will provide more intensive screening to determine the client's risk level. The Contractor will then develop and implement an individual plan of care that addresses the client's multiple health, behavioral and social needs, and that ensures continuity, quality and effectiveness of care.
- Assistance to clients in accessing appropriate medical care, including assisting the client in finding a primary care provider (PCP) if the client does not already have a PCP.
- Assistance to clients in accessing necessary primary/preventive care and obtaining referrals for specialty services through appropriate channels, rather than obtaining care through the emergency department.
- Facilitation of appropriate collaboration between the client's family and/or caregivers, health care providers and community case managers in the development and implementation of the client's plan of care.
- Linkage between health care providers and allied health and social service agencies to facilitate access to services necessary for the implementation of the client's plan of care, including a system that allows providers to request specific care coordination services.

Choice of Providers

The state assures that there will be no restrictions on a client's free choice of providers in violation of Section 1902(a)(23) of the Act. Eligible clients have free choice to receive or not receive disease case management services through contracted Prepaid Health Plans (PHPs) and may change nurse case managers within the PHP at any time. Eligible clients also have free choice of the providers of other medical care under the program.

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State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13. c. Preventive services/Disease State Management (cont.)

Criteria for Disease Management Providers

(a) All Disease Management case managers shall be registered nurses who meet the requirements of the contracted disease management vendors.

All case management nurses shall be licensed in the State of Washington, Registered Respiratory Therapists licensed in the State of Washington may provide additional services.

(b) The State will contract with disease management companies who meet the program requirements.

(c) Entities who wish to contract with the Medical Assistance Administration to provide disease management services must meet the following conditions:

- Have an appropriate method for using MAA healthcare data to identify targeted disease populations;
- Have an evidence-based healthcare practice guideline for each targeted disease;
- Have collaborative healthcare practice models in place to include MAA's contracted physicians and support-service providers;
- Have patient self-care management education materials and methods appropriate to each targeted disease population;
- Have process and outcomes measurement, evaluation, and management systems;
- Have routine reporting processes that are proven to properly support disease management goals;
- Have demonstrable and successful experience in disease management for the targeted disease population;
- Provide access to a 24 hour-a-day, seven days-per-week nurse call center;
- Have the ability to guarantee program savings; and
- Meet applicable federal and state laws and regulations governing the participation of providers in the Medicaid program.

Comparability of Services

All clients eligible to participate in the disease management program will receive comparable services, based on their level of disease and co-morbid conditions. All clients will receive be assessed for their risk level, and will receive follow up education and disease management services.

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13. c. Preventive services/Disease State Management (cont.)

Inclusion Criteria

Target Group: The target group of Medicaid clients eligible to receive Disease Management services are clients who:

(1) Receive medical services through fee-for-service coverage;

(2) Are not institutionalized;

(3) Are high-risk clients with one or more diseases and conditions;

(4) Are not receiving specialized case management services through another program;

(5) Have a primary diagnosis of one of the diseases described in this document.

Enrollment/Disenrollment Process

This disease management program is a voluntary program. All clients in the enrollment group will have access to the toll-free Nurse Advice program. Additionally, those clients with any of the four disease states will be referred to the appropriate DM Vendor for further disease management. Any client may stop participating in the DM program at any time by calling the Disease Management vendor with whom the client is participating, or by calling the State's toll-free customer service line. This process is referred to as "opting out" of the Disease Management Program.

Clients may also re-enroll ("opt in") in the Disease Management Program at any time by calling the appropriate disease management vendor, or the State's toll-free customer service line.

Payment Methodology for the Programs

In accordance with federal interpretation, the disease management contracts are risk contracts. See attachment 4.19-B, IX, G for payment methodology.

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13 d. Rehabilitative services

1. Physical medicine and rehabilitation as requested and approved.

2. Alcohol detoxification is limited to three days in certified facilities which are:

(c) Within the physical location and the administrative control of a general hospital; or

(d) Freestanding facilities established to provide this service.

3. Drug detoxification is limited to five days in certified facilities which are:

(a) Within the physical location and the administrative control of a general - hospital;

(b) Freestanding facilities established to provide this service

4. Adult day health is a supervised daytime program providing nursing and rehabilitative-therapy services. Adult day health services are only appropriate for adults with medical or disabling conditions that require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's physician.

5. Chemical dependency treatment provided in certified programs that include:

(a) Outpatient treatment programs; and

(b) Treatment services, excluding board and room, provided in residential treatment facilities with 16 beds or less.

6. Medical services furnished by a school district:

(a) Including evaluation, screening and assessment component for those students under consideration for an Individual Education Program or Individualized Family Service Plan; or

(b) Identified as part of a handicapped child s Individual Education Program or Individualized Family Service Plan.

Services to be provided will be physical therapy, speech therapy, occupational therapy, audiology, psychological services, counseling, and nurse services. Licensed/ classified personnel will provide services.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13. d. Rehabilitative services (cont.)

7. Mental Health Rehabilitation services are integrated treatment services recommended by a mental health professional furnished by state licensed Community Mental Health Agencies. Services are provided to seriously mentally ill adults and seriously emotionally disturbed children for whom the services are determined to be medically necessary. These services must be provided to reach the goals of an Individualized Service Plan. Payment rates are established per Attachment 4.19-B XVIII.

The services to be provided are:

- Brief Intervention Treatment;
- Crisis services;
- Day Support;
- Family treatment;
- Freestanding Evaluation and Treatment;
- Group treatment services;
- High Intensity Treatment;
- Individual Treatment Services;
- Intake evaluation;
- Medication Management;
- Medication Monitoring;
- Mental Health Services provided in Residential settings;
- Peer Support;
- Psychological Assessment;
- Rehabilitation Case Management;
- Special population evaluation;
- Stabilization Services; and,
- Therapeutic psychoeducation.

A. Definition of medical necessity as it relates to mental health services

Medical necessity or *medically necessary* – "A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause of physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this chapter "course of treatment" may include mere observation, or where appropriate, no treatment at all.

Additionally, the individual must be determined to 1) have a mental illness covered by Washington State for public mental health services; 2) the individual's impairment(s) and corresponding need(s) must be the result of a mental illness; 3) the intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness;

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13 d. 7. Rehabilitative services/Mental health services (cont.)

4) the individual is expected to benefit from the intervention; and 5) any other formal or informal system or support can not address the individual's unmet need.

Medical necessity is determined by a mental health professional. All state plan modality services are accessible based on clinical assessment, medical necessity and individual need. Individuals will develop with their mental health care provider an appropriate individual service plan. The services are provided by Community Mental Health Agencies licensed or certified by the Mental Health Division and provided by, or under the supervision of, a mental health professional. Services are assured in accordance with 1902(a)(23).

The following is a descriptive list of the employees or contracted staff of community mental health agencies providing care.

(1) *Mental health professional* means:
(A) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapter 71.05 and 71.34 RCW;
(B) A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;
(C) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.
(D) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or
(E) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-265.

Within the definition above are the following:

- *"Psychiatrist"* means a person having a license as a physician in this state who has completed residency training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and is board eligible or board certified in psychiatry.

- *"Psychologist"* means a person who has been licensed as a psychologist pursuant to chapter 18.83 RCW;

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13 d. 7. Rehabilitative services/Mental health services (cont.)

- *"Social worker"* means a person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary;

- *"Child psychiatrist"* means a person having a license as a physician and surgeon in this state, who has had graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

- *"Psychiatric nurse"* means a registered nurse who has a bachelor's degree from an accredited college or university, and who has had, in addition, at least two years experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional. "Psychiatric nurse" shall also mean any other registered nurse who has three years of such experience.

- *"Counselor"* means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee.

(2) ***"Mental Health Care Provider"*** means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years experience in the mental health or related fields.

(3) *"Peer Counselor"* means the individual who: has self-identified as a consumer or survivor of mental health services; has received specialized training provided/contracted by the Mental Health Division; has passed a written/oral test, which includes both written and oral components of the training; has passed a Washington State background check; has been certified by the Mental Health Division; and is registered as a counselor with the Department of Health.

Peer Counselors must self identify as a consumer or survivor of mental health services.

Peer Counselors must demonstrate:

1. That they are well grounded in their own recovery for at least one year;
2. Willingness to a pretest for reading comprehension and language composition; and,
3. Qualities of leadership, including governance, advocacy, creation, implementation or facilitation of peer-to-peer groups or activities.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13 d. 7. Rehabilitative services/Mental health services (cont.)

Peer Counselors must be able to:

- Identify services and activities that promote recovery by instilling hope and experiences which lead to meaning and purpose, and which decrease stigma in the environments in which they serve;
- Articulate points in their own recovery stories that are relevant to the obstacles faced by consumers of mental health services;
- Promote personal responsibility for recovery as the individual consumer or mental health services defines recovery;
- Implement recovery practices in the broad arena of mental health services delivery system;
- Provide a wide range of tasks to assist consumers in regaining control over their own lives and recovery process (e.g., promoting socialization, self advocacy, developing natural supports stable living arrangements, education, supported employment);
- Serve as a consumer advocate;
- Provide consumer information and peer support in a range of settings; and,
- Model competency in recovery and ongoing coping skills.

The training provided/contracted by the mental health division shall be focused on the principles and concepts of recovery and how this differs from the medical model, the creation of self-help and coping skills and advocacy. Training will include:

- Understanding the public mental health system;
- What is peer support and how it promotes recovery;
- How to advocate for age appropriate peer support projects;
- How to facilitate groups and teams;
- Understanding self-directed recovery;
- How to create your own self-help coping skills plan;
- How to start and sustain self-help/mutual support groups;
- How to form and sustain a personal support team;
- How to promote recovery, self-determination and community reintegration;
- Assist consumers to do for themselves and each other;
- Assist in skill building, goal setting, problem solving;
- Assist consumers to build their own self-directed recovery tools; and,
- Assist consumers by supporting them in the development of an individual service plan that has recovery goals and specific steps to attain each goal.

Peer Counselors who were trained prior to the implementation of the Washington Administrative Code by National Consultants to be Certified facilitators who pass the test and the background check, and are registered counselors may be grandfathered as Peer counselors until January 2005. After January 2005, it will be necessary for them to take the training.

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13 d. 7. Rehabilitative services/Mental health services (cont.)

(4) *"Registered nurse"* means a person licensed to practice registered nursing under chapter 18.79 RCW.

(5) *"Nurse practitioner"* means a person licensed to practice advanced registered nursing under chapter 18.79 RCW.

(6) *"Licensed practical nurse"* means a person licensed to practice practical nursing under chapter 18.79 RCW.

(7). *"Mental health specialist"* means:

(1) A "*child mental health specialist*" is defined as a mental health professional with the following education and experience:
(a) A minimum of one hundred actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and
(b) The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

(2) A "*geriatric mental health specialist*" is defined as a mental health professional who has the following education and experience:
(a) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of persons sixty years of age or older; and
(b) The equivalent of one year of full-time experience in the treatment of persons sixty years of age or older, under the supervision of a geriatric mental health specialist.

(3) An "*ethnic minority mental health specialist*" is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and
(a) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or
(b) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minority consumers.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13 d. 7. Rehabilitative services/Mental health services (cont.)

(4) A "*disability mental health specialist*" is defined as a mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, "disabled" means an individual with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.

(a) If the consumer is deaf, the specialist must be a mental health professional with:
  (i) Knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and
  (ii) Ability to communicate fluently in the preferred language system of the consumer.

(b) The specialist for consumers with developmental disabilities must be a mental health professional who:
  (i) Has at least one year's experience working with people with developmental disabilities; or
  (ii) Is a developmental disabilities professional as defined in RCW 71.05.020.

Staff Supervision means monitoring the administrative, clinical or clerical work performance of staff, students, interns, volunteers or contracted employees by persons with the authority to direct employment activities and require change. When supervision is clinical in nature, it shall occur regularly and may be provided without the consumer present or may include direct observation of the delivery of clinical care. Supervisory activities include the review of all aspects of clinical care including but not limited to review of assessment, diagnostic formulation, treatment planning, progress toward completion of care, identification of barriers to care, continuation of service and authorization of care.

B. Definitions

(1) *Brief Intervention Treatment*: Solution focused and outcomes oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid enrollee's Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee's current level of functioning and assistance with self/care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13 d. 7. Rehabilitative services/Mental health services (cont.)

(2) *Crisis Services*: Evaluation and treatment of mental health crisis to all Medicaid enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available.

Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

(3) *Day Support*: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

(4) *Family Treatment*: Psychological counseling provided for the direct benefit of a Medicaid enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their individual service plan. This service is provided by or under the supervision of a mental health professional.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13 d. 7. Rehabilitative services/Mental health services (cont.)

(5) "*Freestanding Evaluation and Treatment*" Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to the Medicaid enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care.

Nursing care includes but is not limited to, performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder.

The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow them to be managed at a lesser level of care. This service does not include cost for room and board.

The Mental Health Division must authorize exceptions for involuntary length of stay beyond a fourteen-day commitment.

(6) *Group Treatment Services*: Services provided to Medicaid enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more Medicaid enrolled individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13 d. 7. Rehabilitative services/Mental health services (cont.)

(7) *High Intensity Treatment*: Intensive levels of service otherwise furnished under this state plan amendment that is provided to Medicaid enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual's needs. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing server symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant positions as determined by the individual (e.g., family, guardian, friends, neighbor). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*, etc. Team members work together to provide intensive coordinated and integrated treatment as described in the individual service plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual service plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

Billable components of this modality include time spent by the mental health professionals, mental health care providers, and peer counselors.
*Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality.

(8) *Individual Treatment Services*: A set of treatment services designed to help a Medicaid enrolled individual attain goals as prescribed in their individual treatment plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include, developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid enrolled individual. This service is provided by or under the supervision of a mental health professional.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13 d. 7. Rehabilitative services/Mental health services (cont.)

(9) *Intake Evaluation*: An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a mental health professional.

(10) *Medication Management*: The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.

(11) *Medication Monitoring*: Face-to-face one-on-one cueing, observing, and encouraging a Medicaid enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional. Time spent with the enrollee is the only direct service billable component of this modality.

(12) *Mental Health Services provided in Residential Settings:* A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid enrolled individuals receiving this service present with severe impairment in psychosocial functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment.

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13 d. 7. Rehabilitative services/Mental health services (cont.)

The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

(13) *Peer Support*: Services provided by certified Peer counselors to Medicaid enrolled individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumer's ability to function in the community. These services may occur where consumers are known to gather (e.g., churches, parks, community centers, etc.) Drop-in centers are required to maintain a log documenting identification of the consumer including Medicaid eligibility.

Services provided by Peer counselors to the consumer are noted in the consumers' Individualized Service Plan delineates specific goals that are flexible, tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, but treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available daily no more than four hours per day. The ratio for this service is no more than 1:20.

(14) *Psychological Assessment:* All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumers continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13 d. 7. Rehabilitative services/Mental health services (cont.)

(15) *Rehabilitation Case Management:* A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage, to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned read mission and to increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

(16) *Special Population Evaluation:* evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

(17) *Stabilization Services:* Services provided to Medicaid enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

(18) *Therapeutic Psychoeducation*: : Informational and experiential services designed to aid Medicaid enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plan of care.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13 d. 7. Rehabilitative services/Mental health services (cont.)

These services are exclusively for the benefit of the Medicaid enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional. Classroom style teaching, family treatment, and individual treatment are not billable components of this service.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13. d. Rehabilitative services (cont.)

8. Therapeutic child-care to treat psychosocial disorders in children under 21 years of age based on medical necessity. Services Include: developmental assessment using recognized, standardized instruments play therapy; behavior modification; individual counseling; self esteem building; and family intervention to modify parenting behavior and/or the child's environment to eliminate/prevent the child's dysfunctional behavior. Prior approval is required. Payment rates are established per section X of Attachment 4.19-B

Line staff, responsible or planning and providing these services in a developmentally appropriate manner must have an AA degree in Early Childhood Education or Child-Development or related studies, plus five years' of related experience, including identification, reporting, and prevention of child abuse and/or neglect.

Supervisory staff must have a BA in Social Work or related studies, plus experience working with parents and children at risk of child abuse and/or neglect. Experience can be substituted for education using a 2:1 ratio.
Their responsibilities are for development, implementation and documentation of treatment plans for each child.

Agencies and individual providers must be approved as meeting Medicaid agency criteria and certification requirements under state law as appropriate.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13. d. Rehabilitative services (cont.)

9. Behavior Rehabilitation Services.

Behavior rehabilitative are services provided to children to remediate debilitating disorders, upon the certification of a physician or other licensed practitioner of the healing arts within the scope of their practice within state law. Prior approval is required.

Service Description

Specific services include milieu therapy, crisis counseling and regularly scheduled counseling and therapy, as well as medical treatment.

Milieu therapy refers to those activities performed with children to normalize their Psychosocial development and promote the safety of the child and stabilize their environment. The child is monitored in structured activities which may be recreational, rehabilitative, academic, or a variety of productive work activities.

As the child is monitored, intervention is provided to remediate the dysfunctional behaviors and encourage appropriate responses in a broad range of settings.

Crisis counseling is available on a 24 hour basis, providing immediate short term intervention to assist the child in responding to the crisis and/or stabilize the child's behavior until problems can be addressed in regularly scheduled counseling and therapy sessions.

Regularly scheduled counseling and therapy, as well as psychological testing, is provided. The purpose of which is to remediate specific dysfunctions which have been explicitly identified in a continually updated formal treatment plan. Therapy may be in an individual or group setting.

It may be directed toward the child alone, the child within his/her biological or the adopted family, or the child within his/her peer group. Medical treatment may also be provided. Twenty-four hour nursing is provided for children who are medically compromised to such an extent that they are temporarily unable to administer self care and are impaired medically/developmentally immediate the caretaker's ability to provide medical/remedial care.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

13. d. 9. Rehabilitative services/Behavior rehabilitation (cont.)

Population to be Served

Children who receive these services suffer from developmental disabilities and behavioral/emotional disorders that prevent them from functioning normally in their homes, schools, and communities. They exhibit such symptoms as drug and alcohol abuse; anti-social behaviors that require an inordinate amount of intervention and structure; sexual behavior problems; victims of severe family conflict; behavioral disturbances often resulting from psychiatric disorders of the parents; medically compromised and developmentally disabled children who are not otherwise served by the state agency's Division of Developmental psychological Disabilities; and impairments.

Provider Qualifications

Service include Social Staff: Responsibilities development of service plans; individual, group, and family counseling; and assistance to child care staff in providing appropriate treatment for clients. The minimum qualification is a Masters Degree in social work or a closely allied field.

Child Care Staff: Responsibilities include assisting social service staff in providing individual, group, and family counseling, and therapeutic intervention to address behavioral and emotional problems as they arise. Minimum qualifications require that no less than 50% of the childcare staff in a facility have a Bachelors Degree. Combinations of formal education and experience working with troubled children may be substituted for a Bachelor's degree.

Program Coordinator: Responsibilities include supervising staff, providing overall direction to the program and assuring that contractual requirements and intents are met. Minimum qualifications are to be at least 21 years of age with a Bachelors Degree, preferably with major in study psychology, sociology, social work, social sciences, or a closely allied field, and two years experience in the supervision and management of the group care program for adolescents.

Counselor: Responsibilities include case planning, individual and group counseling, assistance to child care staff in providing appropriate treatment for clients, coordination with other agencies, and documentation of client progress. Minimum qualifications are to be at least 21 years of age possessing a Master's Degree with major study in social one year work or a closely allied field and of experience in the care of troubled adolescents or, a Bachelor's Degree with major study in social work, psychology, experience in the care of troubled adolescents.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

17. Nurse midwife services

Limited to facilities approved by the department to provide this service, or in the case of home births, to clients and residences approved for this service. To participate in home births, midwives must be an MAA-approved provider.

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18. Hospice care (in accordance with section 1903(o) of the Act)

Includes pediatric palliative care services that are provided for approved clients 20 year old and younger who have a life limiting diagnosis.

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20. Extended services for pregnant women, through the sixty days postpartum period

The extended services include:

a. Maternity support services, by a provider approved by the Department of Health and the department, consisting of:

(1) Nursing assessment and/or counseling visits;
(2) Psychosocial assessment and/or counseling visits;
(3) Nutrition assessment and/or counseling visit;
(4) Community health worker visit; and
(5) Child birth education.

b. Outpatient alcohol and drug treatment for pregnant and postpartum women consisting of a chemical dependency assessment by an Alcohol and Drug Abuse Treatment and Services Act assessment center, parenting education, and chemical dependency treatment.

c. Rehabilitation alcohol and drug treatment services, excluding room and board, for pregnant and postpartum women recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under State law. Services are provided in residential treatment facilities with 16 beds or less certified by the Division of Alcohol and Substance Abuse.

d. Genetic counseling performed by a provider approved by Parent-Child Health Services and the department.

e. Smoking cessation counseling, up to ten sessions, to include the following:

(1) Assessing the pregnant and postpartum woman's tobacco dependence;
(2) Providing advice and assistance, including a written smoking cessation plan; and
(3) If appropriate, prescribing smoking cessation pharmacotherapy, as needed.

Smoking cessation counseling may be provided by physicians, advanced registered nurse practitioners, licensed midwives, and physician assistants.

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AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

22. Respiratory care services

As defined in rule, the department covers medically necessary oxygen and/or respiratory therapy equipment, supplies and services to eligible clients in nursing facilities, community residential settings, and in their homes. The above is prescribed by a health care practitioner authorized by law or rule in the State of Washington. Prior authorization is required for specified equipment, or when a request falls outside of the defined criteria.

Selected contracted nursing facilities are authorized to provide exceptional care needs to ventilator- and tracheostomy-dependent clients.

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23. a. Transportation

(1) Ambulance transportation is provided as an optional service for emergencies or as required by state law.

(2) All non-emergency transportation services, to assure clients have access to and from covered services, are provided using administrative matched dollars in accordance with Section 42 CFR 431.53, and are not considered a medical service in the coverage section of the State Plan.

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23. d. Nursing facility services provided for patients under 21 years of age

Admission requires prior approval.

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HIV/AIDS CASE MANAGEMENT SERVICES

A. Target Group:

Clients who have a current medical diagnosis of HIV or AIDS and who are eligible for Title XIX (Medicaid) coverage under the Categorically Needy Program (CNP) or the Medically Needy Program (MNP).

The clients require assistance obtaining and effectively using necessary medical, social, and educational services or the client's condition is such the client requires 90 days continued monitoring.

B. Areas of State in which services will be provided:

[X] Entire State.

[ ] Only in the following geographic areas (authority of section 1915 (g) (1)) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services:

[ ] Services are provided in accordance with section 1902 (a) (10) (B) of the act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a) (10) (B) of the Act.

D. Definition of Services

MAA requires that HIV/AIDS case management providers perform the following functions:

1. Notify HIV positive persons, verbally or by signing a statement, of their choice of available HIV/AIDS case management providers statewide. This requirement does not obligate HIV/AIDS case management providers to accept all clients who request their services. The case management provider will refer the client to another provider.

2. Obtain and maintain a current Authorization to Release/Obtain Information form. The provider must have a valid authorization on file for the months that case management services are billed to MAA. The provider cannot charge the client for services or documents related to covered services.

3. Maintain sufficient contact to ensure effectiveness of ongoing services. MAA requires a minimum of one contact per month between the HIV/AIDS case manager and the client. However, contact frequency must be sufficient to ensure implementation and ongoing maintenance of the Individual Service Plan (ISP).

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HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

D. Definition of Services (continued)

Case management includes services which will assist clients in: living as independently as possible, maintaining and improving their health, reducing behaviors that put themselves and others at risk, and gaining access to needed medical, social, and educational services.

Description of Services:

Case management functions (core and support) are provided under the direction of a qualified case manager and are detailed below.

Core Functions:

Comprehensive Assessment: A comprehensive assessment is an evaluation to determine client's needs for case management services in several areas. This evaluation includes demographic information, physical status, HIV diagnosis, psychological/social/cognitive functioning and mental health history, ability to perform daily activities, financial and employment status, medical benefits and insurance coverage, informal support systems, legal status, and reportable behaviors which could lead to HIV transmission or reinfection.

Service Plan Development: An individual service plan must be developed in conjunction with the comprehensive assessment to identify and document the client's unmet needs and the resources needed to assist in meeting those needs.

Service Plan Implementation: The case manager is responsible for implementation of the service plan, but may delegate specific functions to others, such as the home health nurse, discharge planners, etc.

Service Plan Review: The case manager must review the service plan monthly through in-person contact or by telephone contact with the client.

Narrative Records: Case managers must keep ongoing records, which clearly document case management services. These records must include the reason for the case manager's interaction with the client and the plans in place or to be developed to meet unmet client needs.

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HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

D. Definition of Services (continued)

Support Functions:

Client Advocacy: Intervene with agencies or persons to help individual clients receive appropriate benefits or services.

Assistance: Assist or arrange for the client to obtain a needed service or accomplish a necessary task.

Consultation: Consult with service providers and professionals to utilize their expertise on the client's behalf.

Networking: Help a client to access services through linkages between formal and informal support systems for the purpose of creating an effective continuum of care.

Family Support: Arrange for appropriate referrals to help the family or significant others to deal with stress and changes related to the client's impairments.

E. Qualifications of Providers:

Provider Qualifications – Individual case managers

An HIV/AIDS case manager shall:

1. Be either a professional or a paraprofessional (HIV/AIDS case manager assistant) under the direct supervision of a professional;

2. Be employed and enrolled as an HIV/AIDS case manager by a public or private health, social service, or education agency.

3. Have demonstrated skills and knowledge necessary to perform his/her job responsibilities at the time of employment or have the potential of achieving the required skills and knowledge through training;

4. Have a general knowledge of HIV/AIDS-related conditions and diseases, the AIDSNET service delivery system, and other service delivery systems in his/her community;

5. Meet at least the following requirements for education and experience:

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HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

E. Qualifications of Providers (continued)

(a) Master's degree in behavioral or health sciences (e.g. social work, clinical psychology, sociology, guidance counseling, nursing, and public health) and one year of paid social service experience;

(b) Bachelor's degree in behavioral or health sciences and two years of paid social services experience;

(c) Bachelor's degree and three years of paid social services experience.

HIV Client Services, Department of Health may make exceptions to the above requirements when the service population is geographically or culturally isolated, or has limited English speaking ability.

Provider qualification – Case management agencies

An HIV/AIDS case management agency must:

1. Be a public or private social service, health, or education agency employing staff with HIV/AIDS case manager qualifications;

2. Demonstrate linkage and referral ability with social and health service agencies and individual practitioners;

3. Have experience working with persons living with HIV/AIDS;

4. Meet applicable state and federal laws and regulations governing the participation of providers in the Medicaid program;

5. Have caseload size standards that allow HIV/AIDS case management staff to perform the duties established in the Title XIX HIV/AIDS case management standards;

6. Have supervisors who meet the HIV/AIDS case manager qualifications and have:

   (a) A master's degree and two years of paid social service experience; or

   (b) A bachelor's degree and three years of paid social service experience, including one supervisory year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

HIV/AIDS CASE MANAGEMENT SERVICES (cont.)

F. Choice of Providers

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act. Eligible recipients will have free choice of the providers of:

1. HIV/AIDS case management services; and

2. Other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): ALL

CASE MANAGEMENT SERVICES

A. Target Group:
Persons who are Medicaid recipients (clients) and alcohol- or other drug-dependent who need assistance in obtaining necessary medical, social, educational, vocational, and other services.

B. Areas of State in which services will be provided:

[XX] Entire State

C. Comparability of Services:

[XX] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a)(10)(B) of the Act.

D. Definition of Services:
Case management is an ongoing process to assist eligible clients gain access to and effectively use necessary health and related social services.

Description of Services:
Case management will be used to either involve eligible clients in chemical dependency treatment or to support them as they move through stages of chemical dependency treatment within or between separate treatment agencies.

Core Functions:
The core functions of the case manager are to provide or assist in providing:

Identification of Needs
Complete a comprehensive and on-going assessment of the client's needs for medical, social, educational, and other related services. Address the barriers to accessing or utilizing chemical dependency treatment services and other services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

CASE MANAGEMENT SERVICES (cont.)

D. Definition of services (continued)

Planning
Prepare and implement a written service plan that reflects the client's needs and the resources available to meet those needs in a coordinated, integrated fashion.

Linkage
Facilitate access to needed services through linkages between support systems to avoid duplication of services. These services will augment/reinforce the treatment for chemical dependency.

Advocacy
Intervene with agencies/persons to help clients receive appropriate benefits or services. Also, help the client obtain a needed service or accomplish a necessary task. Be available to help problem-solve when there is a crisis in the client's treatment plan. Advocate for the client's treatment needs with treatment providers.

Accountability
Retain documentation of case management plan and services provided. Submit data as required.

E. Qualifications of Providers:
Case management services will be provided through contracts between the Medicaid agency and chemical dependency treatment agencies certified under Chapter 388-805 WAC in order to ensure that the case managers for these clients are capable of providing the full range of services needed by these targeted clients.

Case management services will be provided by a Substance Abuse counselor who meets the requirements of a certified Chemical Dependency Professional or a Chemical Dependency Professional Trainee as defined in WAC 388-805.

F. The state assures that the provision of case management services will not restrict a client's free choice of providers in violation of Section 1902 (a)(23) of the Act.

1. Eligible clients will have free choice to receive or not receive case management services.

2. Eligible clients will have free choice of the providers of other medical care under the plan.

Payment for case management services under the plan will not duplicate payments made to public agencies or private entities under other program authorities this same purpose.